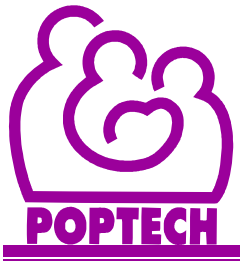

AN ASSESSMENT

OF

USAID REPRODUCTIVE HEALTH AND FAMILY PLANNING

ACTIVITIES IN THE EASTERN EUROPEAN AND EURASIAN REGION

WITH SPECIAL REFERENCE TO ARMENIA, KAZAKHSTAN, AND ROMANIA

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Finally, special thanks go to the staff of the Population Technical Assistance Project (POPTECH), particularly Callie Curtis, Corey Taylor, and Larry Smith, for their tireless support throughout the evaluation.

ACRONYMS

AEEB	Assistance to Eastern Europe and the Baltics
AIHA	American International Health Alliance
ARAS	Romanian Association Against AIDS
ASTP	Armenia Social Transition Program
BCC	Behavior change communication
CDC	Center for Disease Control and Prevention
CEDPA	Centre for Development and Population Activities
CMS	Commercial Market Strategies project
CYP	Couple year of protection
DFID	Department for International Development (United Kingdom)
DHS	Demographic and Health Survey
DOTS	Directly observed treatment, short course
E&E	Eastern European and Eurasian
EEIRH	East European Institute for Reproductive Health
EU	European Union
FP	Family planning
FSA	Freedom Support Act
FY	Fiscal year
GTZ	German Technical Cooperation
HIV/AIDS	Human immunodeficiency virus/acquired immune deficiency syndrome
IEC	Information, education, and communication
IUD	Intrauterine device
JHU/CCP	Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs
JHU/PCS	Johns Hopkins University Population Communication Services
JSI	John Snow, Inc.
KDHS	Kazakhstan Demographic and Health Survey
LMIS	Logistics management information system
MCH	Maternal and child health
MMR	Maternal mortality rate
MOH	Ministry of Health
MSH	Management Sciences for Health
NGO	Nongovernmental organization
PSI	Population Services International
RFHI	Romania Family Health Initiative
RH	Reproductive health
RHS	Reproductive health survey
RTI	Reproductive tract infection
SEATS	Service Expansion and Technical Support Project
SECS	Society for Education on Contraception and Sexuality
SOMARC	Social Marketing for Change project
STD	Sexually transmitted disease
STI	Sexually transmitted infection
TASC II	Technical Assistance and Support Contract (TASC) II project
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
USAID/E&E	Bureau for Europe and Eurasia
USAID/EE/DGST	Office of Democracy, Governance, and Social Transition
WHO	World Health Organization
WIN	Women and Infant Health project
WWC	Women's Wellness Center
YfY	Youth for Youth Foundation

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EXECUTIVE SUMMARY

The objective of this external assessment was to review the extent to which the U.S. Agency for International Development's (USAID's) reproductive health (RH) and family planning (FP) assistance over the past decade in the Eastern European and Eurasian (E&E) region has been effective in addressing the major RH/FP needs of women and men, that is, high levels of unintended pregnancy, excessive reliance on abortion, and high maternal morbidity and mortality (compared with Western Europe and North America), stemming in part from complications resulting from the use of abortion. More specifically, the assessment examined whether USAID assistance has contributed to improved delivery and increased use of modern methods of contraception[1] and other reproductive health care, to reduced reliance on abortion, and to the promotion of new RH/FP initiatives (models) that are effective in contributing to enhanced service availability and use.

USAID's RH/FP programs in many E&E countries have been successful in

- promoting the use of modern contraception as an alternative to abortion,
- training health care professionals in RH/FP,
- establishing contraceptive logistics management information systems,
- providing information and education to target audiences, and
- conducting mass media campaigns.

The E&E countries that have been most successful in providing quality RH/FP care have also had rapidly growing economies, higher levels of government commitment to RH/FP programming, greater USAID Mission support for RH/FP activities, more involvement of the commercial and nongovernmental organization (NGO) sectors, and a greater willingness to integrate RH/FP care into primary and family-centered maternity care.

Program experience has shown that the use of modern contraception is highly effective in reducing the number of unintended pregnancies and abortions. In many E&E countries, women have indicated that if they were given alternatives, they would not seek an abortion. Evidence clearly shows that most of the E&E countries that have achieved substantial gains in the use of modern contraception have also recorded sizeable declines in abortion rates.

There is considerable potential to further reduce abortion levels in the E&E region if the use of modern RH/FP care is further enhanced. For levels to drop, it will be necessary to ensure proactive policies that support programs providing family planning services and to ensure that contraceptives are reliably procured and distributed. In many E&E countries, increased attention also will need to be given to the rising cost of RH/FP care to ensure access to care, especially among more vulnerable populations. Making greater efforts to improve the income and working conditions of medical doctors and nurses/midwives

[1] Modern methods of contraception include contraceptive sterilization, intrauterine devices (IUDs), hormonal methods, condoms, vaginal barrier methods, Standard Days Method, and lactational amenorrhea method, most of which require supplies or clinical services. Traditional methods include abstinence, withdrawal, and the calendar rhythm method (United Nations Population Division 1999:2).

could also help stem the growing incidence of informal, offsite (not in an appropriate medical facility) abortions that serve as a source of salary supplementation.

The importance of RH/FP for maternal and child health has not been sufficiently promoted in the E&E region. The role of modern contraception in spacing births, reducing unintended pregnancies, and reducing the risk of maternal morbidity and mortality resulting from unsafe abortions should be given greater prominence in communication efforts.

Future priority countries should include Albania, Armenia, Azerbaijan, and Georgia. For example, Georgia and Azerbaijan have total abortion rates of 3.7 and 3.2, respectively, per woman, while the U.S. abortion rate in 2000 was only 0.7 per woman. Georgia and Azerbaijan also have low levels of modern contraceptive use at 20 and 17 percent, respectively. Countries with more advanced HIV/AIDS epidemics, such as Romania, Russia, and the Ukraine, also will deserve special attention.

These general findings inform the following priority recommendations pertaining to future USAID RH/FP programming in the E&E region.

RECOMMENDATIONS

Continue Long-Term Assistance for RH/FP Programs in the E&E Region

It is essential that funding for RH/FP programs continue at a substantial level in the E&E region. Countries with the highest abortion and maternal mortality rates and the lowest levels of modern contraceptive use should receive greater priority in future USAID allocations. Given the small desired family size in many E&E countries, it is likely that the demand for abortion will remain high unless modern contraception can be made more accessible.

Expand Successful Pilot Interventions

Much USAID support for RH/FP programs in the E&E region has been in the form of demonstration (pilot) projects. Several program models implemented by USAID have been successful in improving RH/FP care accessibility and quality, such as

- the integration of RH/FP care with primary health care,
- the integration of RH/FP care with family-centered maternity care,
- the provision of increased support for postabortion RH/FP care,
- more sustainable Women's Wellness Centers that are better coordinated with national RH/FP programs, and
- the expansion of RH/FP counseling and care specifically designed for youth.

While these activities have often produced impressive results, national-level impacts will be limited if successful pilot programs cannot be replicated and expanded.

Promote Greater Contraceptive Security in the E&E Region

Without a reliable supply of modern contraceptives, it will not be possible to make significant progress in providing RH/FP care. USAID should assist governments in improving their contraceptive management capacity and plans for ensuring sustainable and self-reliant procurement operations. Such plans should also enable governments to ensure that contraceptive supplies are available to most vulnerable population groups.

Expand Social Marketing Efforts Combining Behavioral Change and Targeted Commodity Distribution Approaches

USAID should assist governments in the E&E region to strengthen contraceptive social marketing programs to better serve high-risk (vulnerable) groups. In countries with small potential commercial markets (e.g., nations in the Caucasus), regional approaches in which similar product lines are introduced in several countries should be considered.

Promote Preservice Training and Curriculum Reforms in Supporting the Strengthening of Family Doctor and Family Group Practice Service Delivery

In supporting the introduction of new RH/FP standards and protocols and the training of family doctors, emphasis has been given to inservice training. Surprisingly little attention has been given to preservice training. The introduction of new RH/FP training curricula in medical schools responsible for graduating new family practitioners is an important priority in many settings. Such initiatives will help ensure that health sector reforms introduced in many E&E countries will become permanent features of the region's newly restructured health delivery systems.

I. INTRODUCTION

PURPOSE

The purpose of this assessment was to determine whether the U.S. Agency for International Development's (USAID's) assistance in reproductive health (RH) and family planning (FP) over the past decade has contributed to improved delivery and increased use of modern methods of contraception and other reproductive health care. The assessment had three main objectives:

- provide an overview of the magnitude, nature, and pattern of USAID assistance in RH/FP in the Eastern and European (E&E) region over the past decade;

- capture lessons learned and assess best practices in three representative countries (and subregions) in the E&E region, and assess the extent to which overall USAID assistance, particularly through specific models of assistance, can be plausibly associated with changes in the availability and nature of RH/FP care, use of modern methods of contraception, and reduction of abortion; and

- identify opportunities for future directions in support of RH/FP and ways to improve the impact of assistance on FP use and the reduction of abortion.

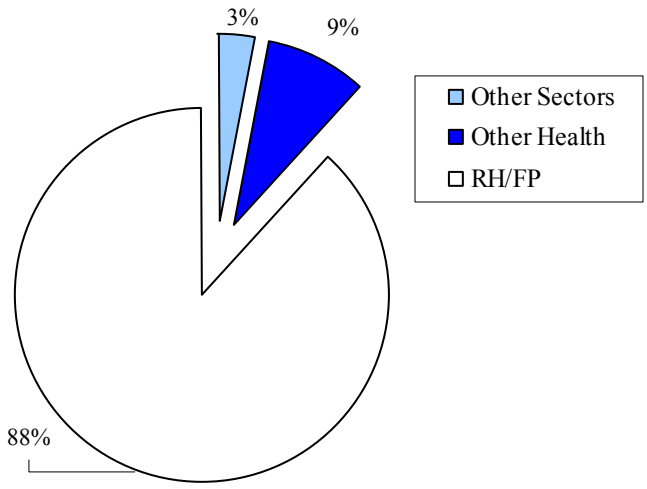
(The scope of work for the assignment is presented in appendix A.)

BACKGROUND

Concerns about the adverse impact on women's health in the E&E region, due to the excessive use of abortion, led to USAID's decision in the mid–1990s to begin promoting the use of modern contraception. The most recent figures show that during the nine-year period from fiscal year (FY) 1996 through FY 2004, USAID expended slightly more than $130 million on RH/FP programs in 15 countries in the E&E region. More than half of these estimated expenditures were in four countries: Armenia, Romania, Russia, and the Ukraine. Support for RH/FP programs has continued with support from Congressional earmarks and directives related to Assistance to Eastern Europe and the Baltics (AEEB) and Freedom Support Act (FSA) resources. In 2004, Congress made available an additional $17 million in child survival health funds. These were redirected from the United Nations Population Fund (UNFPA) to promote family planning and reduce the number of abortions in six E&E countries: Albania, Azerbaijan, Georgia, Kazakhstan, Romania, and Russia.

As of FY 2003, only 12 percent of total funding from USAID's Bureau for Europe and Eurasia (USAID/E&E) was provided for health, one of the lower allocations for health within USAID's regional bureaus. As can be seen in figure 1, only 3 percent of total E&E spending in FY 2003 was dedicated to RH/FP. Within the total E&E health budget, 26 percent of total health spending supported RH/FP projects.

Figure 1
Percentage of USAID/E&E Funding for RH/FP Versus Other Sectors
(FY 2003)



For several decades, abortion has been the primary means of birth prevention in most of the former Soviet bloc countries. Abortion rates in many E&E countries have been among the highest in the world. In a number of countries, the total abortion rate exceeds the total fertility rate. Of particular concern are the abortion rates in Georgia and Azerbaijan (3.7 and 3.2 per woman, respectively, over the reproductive life span). Although abortion without restrictions is generally available and legal during the first 12–14 weeks of gestation, some women seek abortions outside the formal health care system. This may in part explain why the number of abortions estimated through population-based surveys is considerably higher than indicated in official service statistics. Unsafe abortion is one of the leading causes of maternal mortality and morbidity in the E&E region. It is estimated that between 15 and 54 percent of maternal deaths in the region are related to abortion, and likely result primarily from illegally performed abortions.

USAID programs have promoted modern contraceptives as an alternative to abortion by strengthening the systems by which modern contraceptives are provided, training health care professionals in family planning, establishing contraceptive logistics management and information systems, providing information and education to target audiences, and conducting mass media campaigns. USAID, along with host country governments, other donors, and private groups, has also supported a wide variety of RH/FP assistance programs and projects. These include the

- addition or improvement of RH/FP care in government maternal and reproductive health facilities;
- training of health care professionals in RH/FP service delivery;
- creation of special women's care or wellness centers, often through partnerships with U.S. institutions;
- addition of prenatal and postnatal care to RH/FP programs;

- integration of RH/FP information, referral, and/or care in primary health care facilities;

- provision of RH/FP information and care in family group health care practices; and

- provision of RH/FP information and care through special family planning initiatives, such as social marketing and media campaigns.

While family planning use has increased in almost all countries, major challenges remain. For example, many countries in the region face serious shortages of contraceptive supplies, lack information on modern methods, are overly reliant on intrauterine devices (IUDs), and have unnecessarily high abortion rates. Of particular concern is the low use of modern methods of contraception (e.g., Albania's rate of 8 percent), inadequate training of general practitioners and family doctors in FP, and systemic health system dynamics that encourage health providers to promote abortion rather than contraception and also encourage women to choose abortion as the most affordable and feasible alternative to unintended pregnancy.

During Soviet times, health care systems in the E&E region were typically provided by the state, with all health care provided by state employees. The system was highly centralized and standardized, with free services provided in state-owned facilities. The system was generally successful in providing universal access to services, although the quality of care was often suboptimal. In addition, this system required substantial state financial support.

With the dissolution of the Soviet Union, economies in many countries collapsed. Without adequate financing, many health care facilities fell into disrepair as scarce resources constrained the governments' ability to implement health care reforms. Moreover, the legacy of a top-down approach to health care administration discouraged individual initiatives and institutional development. This environment resulted in low health care facility use, worsening health indicators, and general public discontent with the health care systems.

METHODOLOGY

This assessment was conducted under the guidance of the team leader for USAID's Bureau for Europe and Eurasia, Office of Democracy, Governance, and Social Transition health team (EE/DGST), and the senior family planning adviser in USAID/E&E. As a first step, the assessment team developed a common protocol for field reviews in the three countries visited as part of this assessment: Armenia, Kazakhstan, and Romania. The countries selected were thought to be representative of the three E&E subregions, that is, the Caucasus, the Central Asian Republics, and Eastern Europe.

The team followed a common protocol for obtaining information in each country (see appendix B for the persons contacted). In order to gain a comprehensive perspective, the team focused on national and regional changes rather than individual project findings. In those cases where program assistance has ended, the team sought to determine whether improved service delivery systems were being continued, services were being provided, and contraceptives were readily available.

The team reviewed a wealth of background materials before and during the assessment (see the final appendix). Extensive use was also made of a valuable desk review of USAID–supported RH/FP activities in the E&E region that had been prepared before the assessment began.

II. OVERVIEW OF POPULATION, REPRODUCTIVE HEALTH, AND FAMILY PLANNING CONDITIONS IN USAID–SUPPORTED COUNTRIES IN THE EUROPEAN AND EURASIAN REGION

Demographic conditions in Eastern Europe and Eurasia more closely approximate conditions in Western Europe and North America than countries in the developing world. Current estimates indicate that most countries in the E&E region have fertility rates lower than the replacement level of 2.1 births per woman (see table C–1 in appendix C). The lowest fertility rates in the region are found in Romania, Russia, and the Ukraine (estimated between 1.2 and 1.3 births per woman). Primarily because of the region's low fertility levels, many countries are experiencing negative population growth.

As can be seen in table C–1, United Nations estimates of life expectancy in the region are somewhat lower than in Western Europe and North America but are well above levels reported in most developing countries. However, the region is notable for the marked differences in life expectancy between men and women. In such countries as Kazakhstan, Russia, and the Ukraine, women currently outlive men by more than 10 years. No region in either the developed or developing world currently has such large gender differences in health status and longevity.

Even though male morbidity and mortality have emerged as significant health issues in many E&E countries, women's reproductive health also continues to be a major concern. The region is still typified by high rates of abortion, low use of modern contraception, excessive maternal morbidity and mortality compared with Western Europe and North America, and poor maternity care.

The incidence of reproductive tract infections (RTIs) and sexually transmitted diseases (STDs) is also high in many E&E countries. This has led to growing fears that HIV/AIDS could grow rapidly throughout the region once it begins to spread from vulnerable subgroups (such as drug users and prostitutes) to the general population. HIV/AIDS infections among young adults aged 15–24 have already reached alarming levels in some Eastern European countries. Recent estimates indicate that nearly 2 percent of Romania's young adults are now testing positive for HIV/AIDS, followed by Estonia (1.5 percent), the Ukraine (1.4 percent), and Russia (1.3 percent) (UNFPA 2004).

The use of modern contraception is still quite low in most E&E countries. The lowest rates of modern contraceptive use tend to be found among countries in the Caucasus region (Armenia, Azerbaijan, and Georgia), but low modern method use can also be found in some Eastern European countries, especially Albania, where the rate of 8 percent is below the levels found in most underdeveloped countries (see table C–2 in appendix C). Some countries in the region have not yet conducted national demographic and health surveys or reproductive health surveys (RHSs) that allow for the estimation of unmet need for family planning services. Where this information is available, 6–24 percent of currently married women report that they are not using contraception and would like to delay the birth of their next child or have no additional children. Unmet limiting need tends to exceed spacing need in the E&E region.

In the E&E region, the most commonly used modern method is the IUD. As is shown in table C–3 of appendix C, the use of hormonal contraception is generally quite low,

especially among countries in the Caucasus and Central Asia. Recent survey data indicate that the use of oral contraception is highest in Romania (8 percent of currently married women aged 15–44) and Russia (7 percent), but nearly negligible in such countries as Armenia, Azerbaijan, Georgia, and Turkmenistan (no more than 1 percent). Condom use is also quite low in the Caucasus and Central Asia, where no more than 8 percent of couples are using condoms. Somewhat higher condom prevalence is reported in such countries as Russia (16 percent) and the Ukraine (14 percent).

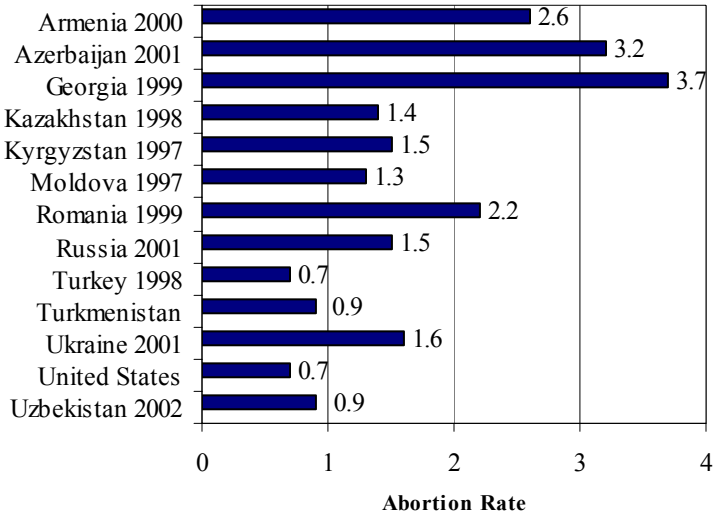
Traditional methods of contraception (primarily withdrawal) are still widely practiced in Eastern Europe and the Caucasus. In these regions, traditional methods often constitute 20–40 percent of overall contraceptive prevalence. However, in Central Asia, fewer than 10 percent of currently married women report using traditional methods. The ratio of modern to traditional method use is actually much higher in such countries as Kazakhstan, Kyrgyzstan, and Uzbekistan than in Russia and the Ukraine. Many women in the E&E region who rely on traditional methods believe that they are effective and free of the side effects that modern contraceptives are perceived to have.

The public sector continues to be the main source of supply for modern contraception in most E&E countries (see table C–4 in appendix C). However, due in part to USAID's social marketing efforts in several E&E countries, commercial distribution is becoming far more common. Currently married women in Romania and Russia rely more on commercial outlets than on public and private providers when obtaining contraceptive supplies. Throughout the E&E region, oral contraceptives and condoms are most likely to be acquired through pharmacies, while IUDs are more typically supplied through public facilities (primarily polyclinics and maternity hospitals). However, at the country level, there are some exceptions worth noting. For example, oral contraceptives are still largely procured from public service outlets in Armenia, Turkmenistan, the Ukraine, and Uzbekistan.

For many decades, women in the E&E region have relied on abortion to regulate their fertility. While levels of abortion had fallen substantially in many countries due to the recent increase in modern contraceptive use, survey information indicates that the region continues to be typified by some of the world's highest total abortion rates (the number of abortions per woman over the reproductive life span). For example, currently married women in Azerbaijan and Georgia still have an average of more than three abortions before completing their childbearing years. Georgia's rate of 3.7 per woman is possibly the highest rate in the world. In other E&E countries, women typically have between 1 and 3 abortions (see figure 2 on the following page).

It should be noted that there is still considerable uncertainty concerning actual levels of abortion in many E&E countries (see table C–5 in appendix C). Abortion estimates from surveys tend to be far higher than official government statistics. For example, the general abortion rate (the number of abortions per 1,000 women) in Georgia was 125 when estimated from survey information and only 18 in official government statistics. Similar discrepancies are reported for other E&E countries, most notably Armenia and Azerbaijan. While survey data clearly establish that official government abortion figures are often substantially underreported, there is also some doubt surrounding the reliability of survey information on abortion. Both surveys and official government statistics may significantly undercount the number of unofficial, offsite (not in an appropriate medical facility) abortions thought to be occurring in many E&E countries.

Figure 2
Total Abortion Rates per Woman



Source: Figures are based on the three prior years (except single year shown for Russia and the United States), U.S. Department of Health and Human Services (2003:38), and Westoff (2004).

There can be little doubt that many women in the E&E region still rely on abortion when unintended pregnancies take place. Survey data presented in table C–6 of appendix C show that the majority of pregnancies occurring in countries situated in Eastern Europe and the Caucasus are unintended. More than 80 percent of these unintended pregnancies are aborted. The percentage of pregnancies that are unintended is substantially lower in Central Asian countries, although nearly 75 percent of these pregnancies are also aborted. These findings clearly suggest that the number of abortions throughout the E&E region could be substantially reduced if the number of unintended pregnancies was reduced. Providing more comprehensive information and counseling on RH/FP and improving the accessibility and quality of family planning services are key interventions for reducing the number of unintended pregnancies.

Complications stemming from the use of abortion continue to be a major cause of maternal morbidity and mortality (see table C–6 in appendix C). Survey results suggest that abortion complications are often high in many E&E countries. For example, 16 percent of all abortions in Azerbaijan and 14 percent in Russia and the Ukraine resulted in complications, although it is not possible to establish the severity of these problems from survey responses. When abortions are safely performed and proper infection control procedures followed, complications should be far below levels typically reported by surveys in the region. There is also some doubt regarding the reliability of abortion complication statistics in demographic and health survey and RHS studies, especially in capturing complications stemming from unofficial abortions that likely entail higher risks.

Maternal mortality in the E&E region is high compared with most developed countries. For example, the maternal mortality rate (MMR) was estimated at about 94 maternal deaths per 100,000 births in Azerbaijan, 67 in Russia, and 49 in Romania as of 2000. The average estimate for all developed countries for the same year is 20 (AbouZahr and

Wardlaw, no date); in 2002, the MMR in the United States was 12. However, it is important to note that several E&E countries have recorded substantial decreases in maternal mortality over the past decade. One of the most dramatic declines has occurred in Romania, where the MMR fell from 170 in 1989 to 20 by 2002. The MMR resulting from abortion complications fell from 148 in 1989 to 18 by 2002, a dramatic drop that coincides with a rapid gain in the use of modern contraception (Ashord 2003:3).

As modern contraceptive use has increased in the E&E region, abortion rates have declined. Most countries that have recorded major gains in modern contraceptive use have also experienced decreases in abortion. Romania provides a dramatic example of this pattern. In the five years before 1999, the use of modern contraception rose by 14 percent. Over approximately the same period, the total abortion rate fell by 1.2 abortions per woman (see table C–7 in appendix C). Georgia, Moldova, and Russia have also seen the abortion rate decline as modern contraceptive use became more prevalent. Only Azerbaijan, Turkmenistan, and the Ukraine have not reported declines in abortion as the use of modern contraception rose (Westoff 2004). However, it can be reasonably anticipated that abortion rates will also begin to decline in these countries once modern contraception becomes more widely used.

This expectation is based largely on the empirical association that has now been well established between the use of modern contraception and the rate of abortion. As is shown in figure C–1 of appendix C, E&E countries with more than 40 percent of currently married women using modern contraception have total abortion rates well below 2. Countries with the highest total abortion rates (above 2) also have the lowest levels of modern contraceptive use (below 30 percent). Similarly, countries that rely more on traditional contraception tend to have higher abortion rates, largely due to higher rates of method failure that entail greater proportions of unintended pregnancies. The low cost of abortion in many E&E countries (which can be less than a monthly cycle of oral contraceptives) and the income supplementation afforded to medical doctors for performing abortions unofficially and offsite are other factors responsible for the region's high incidence of abortion.

Recent survey data from Armenia, Kazakhstan, and Romania analyzed by Westoff (2004) show that the general abortion rate has fallen in all three countries since 1991 (see figure 3 on the following page). However, abortion rates still remain well above levels in the United States. As can be seen in figure 4 (following page), the use of modern contraception rose substantially during the years when abortion rates were declining. Between 1991 and 1998, Kazakhstan's abortion rate fell by nearly 50 percent while the percentage of currently married women using modern contraception rose from 26 to 39 percent. By way of comparison, 71.6 percent of currently married women in the United States were using a modern method of contraception in 1995 (Population Reference Bureau 2002:4).

Figure 3
Recent Trends in the Abortion Rate in Armenia, Kazakhstan, Romania, and the United States
(Abortions per 1,000 women aged 15–44)

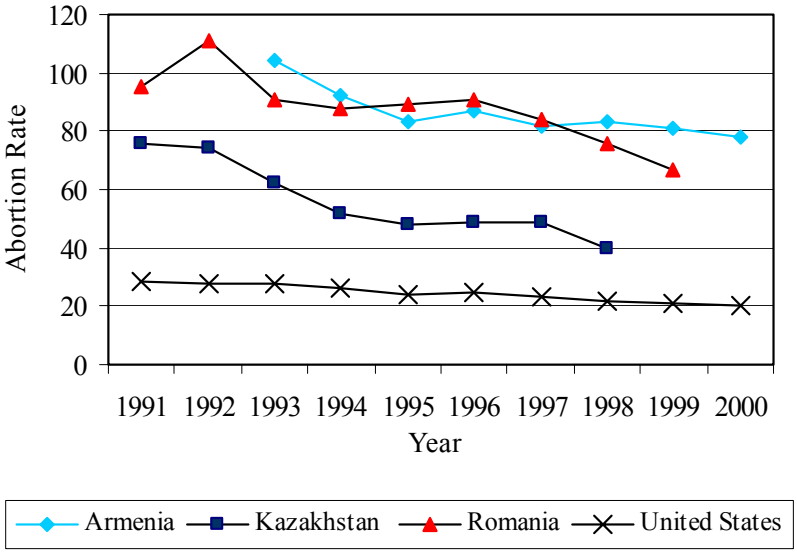
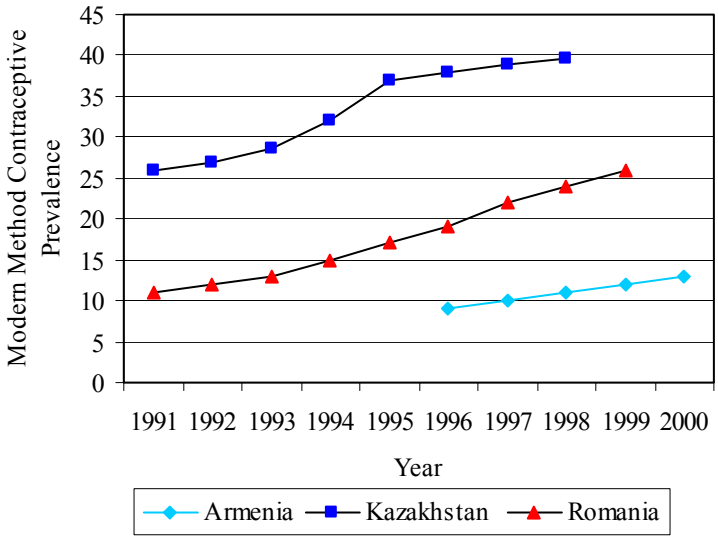


Figure 4
Percentage of Currently Married Women Using Modern Contraception in Armenia, Kazakhstan, and Romania*
(Aged 15–44)

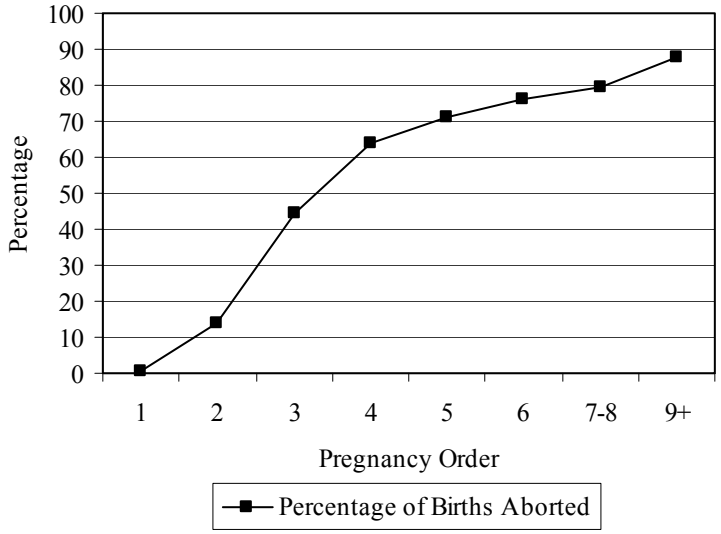


*U.S. modern method contraceptive prevalence equaled 72 percent in 1995

The extent to which abortion is still used to control family size in some E&E countries is dramatically illustrated in figure 5 on the following page. According to the 2000 Armenia Demographic and Health Survey (DHS), 55 percent of all pregnancies still end in abortion. Forty-four percent of all third pregnancies and more than 60 percent of fourth and higher order pregnancies are aborted (DHS Analytical Study 6, 2002:8). Since the mean ideal number of children is just 2.7 in Armenia, one can safely assume that many third and higher order pregnancies were unintended (DHS StatCompiler, 2004). With

increased use of modern contraception, the number of unintended pregnancies could decline further, thereby reducing the need for Armenian women to rely on abortion to achieve desired numbers of offspring.

Figure 5
Percentage of Pregnancies in Armenia That Ended in Abortion by Pregnancy Order

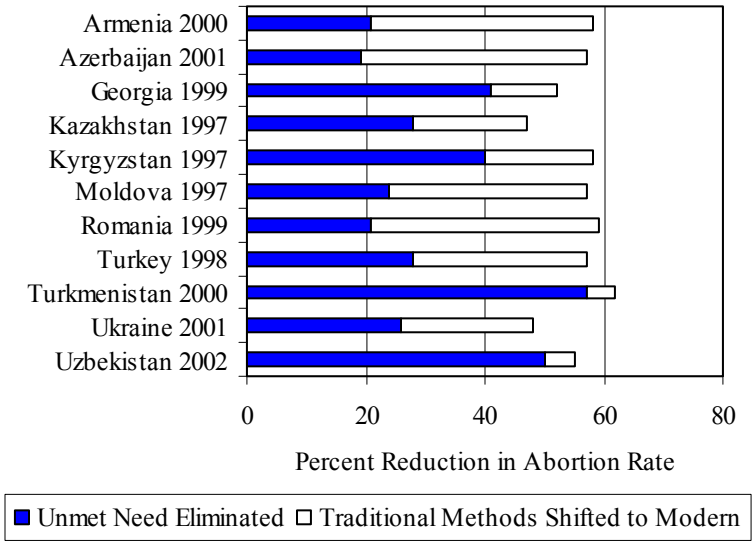


Source: Armenia DHS 2000

While access to modern contraception has been improving throughout the E&E region, overall modern method prevalence is still low by the standards of most developed countries. Unmet need and method failure stemming from the use of traditional methods still result in high rates of unintended pregnancy and abortion. Westoff (2004) has estimated that abortion rates could be reduced 47–65 percent in E&E countries if modern methods of contraception were employed to reduce high levels of contraceptive failure and unmet need (see figure 6 on the following page). The greatest reductions in abortion rates resulting from eliminating unmet need would occur in Turkmenistan (–57 percent), Uzbekistan (–50 percent), Georgia (–41 percent), and Kyrgyzstan (–40 percent). Reducing method failure to levels typified by modern methods would have the greatest impact on abortion in Azerbaijan and Romania (both down by 38 percent), and Armenia (–37 percent).

Other basic reproductive health care also tends to be underused in many E&E countries (see table C–8 in appendix C). While the percentage of women lacking any prenatal care during pregnancy is generally low throughout the E&E region (with Azerbaijan standing out as a major exception), many women do not have any contact with antenatal care providers during the early months of their pregnancies. For example, 83 percent of expectant mothers in Russia do not obtain any prenatal care during the first 3 months of their pregnancies. Postnatal care up to 6 months following delivery is also not a common feature of RH/FP care in most E&E countries. More than half of all mothers receive no postnatal care in Moldova and the Ukraine, and many countries do not have coverage statistics for this important service.

Figure 6
Percent Reduction in Abortion Rates if All Unmet Need and All Traditional Method Use Shifted to Modern Methods



Source: Westoff 2000

Survey data from Eastern Europe and the Caucasus also point to low use of other essential reproductive health care and practices (see table C–9 in appendix C). For example, in Armenia, Azerbaijan, and Georgia, less than one third of all currently married women have had a pelvic examination in the 12–month period before the interview. Less than 50 percent of all survey respondents have ever performed breast self-examinations, and cervical cancer screening is generally uncommon throughout the region. These low coverage levels, combined with the high incidence of RTIs and sexually transmitted infections (STIs), point to serious deficiencies in the accessibility and quality of RH/FP care in many E&E countries.

III. REPRODUCTIVE HEALTH AND FAMILY PLANNING STRATEGIES SUPPORTED BY USAID IN THE EUROPEAN AND EURASIAN REGION

USAID has implemented several strategic approaches in the E&E region to increase modern contraceptive use, reduce abortions, and improve the availability and quality of RH/FP care. Eight strategies were identified during this assessment that have been introduced in the E&E region to achieve USAID's goals:

- data collection, analysis and, dissemination;
- policy dialogue and advocacy;
- nongovernmental organization (NGO) development and support;
- training and quality improvement;
- management assistance and institutional development;
- RH/FP care expansion;
- behavior change communication (BCC) activities; and
- contraceptive security initiatives.

In addition, five discrete approaches implemented by USAID–funded projects to expand the availability and accessibility of RH/FP care were identified:

- integration of RH/FP care into primary health care (including maternity care),
- creation of model service sites,
- social marketing of contraceptives,
- establishment of services specifically designed for youth, and
- postabortion family planning.

Tables 1 and 2 provide a breakdown of strategies and approaches implemented in each E&E country. The following section describes these principal approaches.

Table 1
Strategies Implemented in E&E Countries

	Data Collection	Policy Dialogue	NGO Support	RH/FP Training	Management Assistance	Service Expansion	BCC	Contraceptive Security
Eastern Europe								
Albania	✓	✓		✓		✓	✓	
Moldova	✓							
Romania	✓	✓	✓	✓	✓	✓	✓	✓
Russia	✓	✓		✓				
Turkey	✓	✓	✓	✓	✓	✓	✓	✓
Ukraine	✓	✓	✓	✓		✓		
Caucasus								
Armenia	✓	✓		✓	✓	✓		
Azerbaijan	✓							
Georgia				✓		✓	✓	
Central Asia								
Kazakhstan	✓	✓		✓		✓	✓	
Kyrgyzstan	✓	✓		✓		✓		
Tajikistan	✓	✓		✓		✓		
Turkmenistan	✓	✓		✓		✓		
Uzbekistan	✓	✓		✓		✓		

Table 2
Interventions Implemented To Expand RH/FP Service Delivery

	RH/FP Integration With Primary Health Care	RH/FP Integration With Maternity Care	Women's Wellness Centers	Contraceptive Social Marketing	Youth Services	Postabortion Family Planning
Eastern Europe						
Albania	✓		✓			
Moldova			✓			
Romania	✓		✓		✓	✓
Russia	✓	✓	✓			✓
Turkey	✓	✓		✓		✓
Ukraine	✓		✓			
Caucasus						
Armenia	✓	✓	✓			
Azerbaijan			✓			
Georgia	✓	✓	✓	✓		
Central Asia						
Kazakhstan	✓		✓	✓		
Kyrgyzstan	✓					
Tajikistan	✓					
Turkmenistan	✓					
Uzbekistan	✓		✓			

DATA COLLECTION, ANALYSIS, AND DISSEMINATION

A common finding in all E&E countries is that official health statistics tend to be inaccurate. Underreporting stems primarily from three factors. First, regulations that favor abortion over contraceptive use still prevail in many countries. Second, RH/FP care is sometimes provided by private practitioners who can be reluctant to report statistics to public authorities. Third, different definitions are sometimes employed to measure demographic and health outcomes. For example, official statistics in many E&E countries do not consider premature live births that subsequently do not survive as infant deaths.

USAID has supported population-based RH/FP surveys in 12 countries since 1993—either as DHSs through ORC Macro or as RHSs undertaken by the Centers for Disease Control and Prevention (CDC). These surveys provide baseline measures for USAID's programs, and when they are repeated, supply information for monitoring change over time. Other international organizations as well as local institutions have been using this information for policy development and program evaluation. Surveys are typically conducted by local institutions in collaboration with USAID–funded projects and serve as mechanisms for improving local data collection and analysis capacities.

As funding levels decrease, some USAID Missions may be increasingly reluctant to support population-based surveys since they are expensive to conduct. For example, the Mission for the Central Asian Republics is not currently planning to support future surveys. Other Missions (such as USAID/Romania) intend to support at least one additional follow-on survey, although on a much smaller scale. Nonetheless, several Missions are choosing other mechanisms for gathering data (e.g., the Ukraine, through the use of rider surveys).

POLICY DIALOGUE SUPPORTING ACCESS TO CONTRACEPTION AS AN ALTERNATIVE TO ABORTION

Efforts to change RH/FP policies and regulations have been important initiatives in most E&E countries. These activities included policy dialogue with key officials to

- expand RH/FP care,
- decentralize care,
- authorize broader cadres of health personnel to provide RH/FP, and
- remove legal and regulatory barriers to contraceptive procurement and distribution.

Policy work has been undertaken by the POLICY Project of Futures Group as well as by Abt Associates Inc., John Snow, Inc., (JSI), and the PRIME II Project. These policy dialogues have often been part of broader initiatives to integrate RH/FP into primary health care and to include RH/FP as integral elements of health systems in the E&E region.

Results of policy-related activities vary greatly across the region. In most countries, the development of national RH/FP strategies and care standards has been an essential step for service improvement and expansion. In Romania, policy changes by the government allow general practitioners to provide RH/FP care. This has been a major factor in improving service availability and enabling rural family practitioners to provide RH/FP care in remote rural areas. In Armenia and Kazakhstan, policy changes that authorized the creation of family group practices were instrumental in the integration of RH/FP care with primary health care.

The impact of policy dialogues and advocacy efforts seems to be most effective when activities have been closely coordinated with health sector reforms. For example, efforts to integrate RH/FP with primary health care in Kazakhstan have built upon broader ongoing reforms of the country's entire health system. In Georgia, health reform initiatives are still in their infancy and RH/FP policy changes have been insignificant.

NGO DEVELOPMENT AND SUPPORT

Several USAID–supported projects have worked to strengthen the capacity of NGOs working in RH/FP. New NGOs have been formed; health providers have been trained in contraceptive counseling and technology as well as management and advocacy skills. USAID has also funded the POLICY Project in order to build NGO networks in Russia and the Ukraine to better promote RH/FP care and to advocate for health sector policy reforms. In Romania, two NGOs, the Society for Education on Contraception and Sexuality (SECS) and the Youth for Youth Foundation (YfY), have been on the forefront of advocacy, BCC, and training activities.

However, the development of the NGO sector has not been uniform throughout the region. In many countries, the NGO sector is still weak. In Russia, for example, NGOs do not have a significant role in RH/FP activities; in Armenia, the NGO sector remains

relatively underdeveloped. While some NGOs have established model clinic sites, NGOs are usually not major service providers within the E&E region because of the strong presence of public services and the growth of private medical practices. In addition, the extent to which the POLICY Project's NGO networking activities have been instrumental in advancing the cause of RH/FP service expansion is not clear; no independent evaluation of these activities has been undertaken in recent years. Certainly, such networking still holds considerable promise for strengthening the work of NGOs in the E&E region.

TRAINING AND QUALITY IMPROVEMENT

USAID programs have placed considerable emphasis on training service providers in RH/FP throughout the E&E region. Clinical and counseling training have been the cornerstone of most of the training efforts, conducted mostly through JHPIEGO, the PRIME II Project, and JSI. Training activities have been most extensive in Russia, Kazakhstan, and Romania, where thousands of trainers and providers have been exposed to new RH/FP practices. For example, between 1995 and 2000, approximately 1,000 health care providers were trained in the Ukraine through the Women's Reproductive Health Initiative. The Red Apple social marketing project has trained over 100 trainers, 1,000 physicians, and 1,000 pharmacists in the Central Asian Republics region, and the SEATS II project in Albania (implemented by JSI) has provided instruction for over 1,000 service providers and 250 pharmacists. In Romania, more than half of all general practitioners providing primary health care have been trained in RH/FP. In addition, inservice training has been provided to a wide range of health professionals in order to upgrade their skills and knowledge.

Another important initiative has been the development of new service standards/guidelines and training curricula. Updated training tools for RH/FP have now been designed and distributed in many E&E countries. However, the effectiveness of these new training materials has not been extensively evaluated, particularly with respect to their incorporation into formal medical school curricula. Preservice training is certainly an area that needs to be developed further. Updated RH/FP practices have usually not been incorporated into the curricula of medical and public health schools. Physicians and other health personnel are still often taught through the curricula of the traditional system and then must undergo updated inservice training—a sequence that is not cost-effective.

MANAGEMENT ASSISTANCE AND INSTITUTIONAL DEVELOPMENT

USAID–funded projects have worked with public and private sector institutions in building the management capacity of local partners. By identifying the capabilities and resources of local organizations, these projects have sought to encourage and develop sustainable institutions that can support RH/FP and lead to a greater sense of involvement and ownership within participating communities.

Management assistance and organizational capacity-building efforts have produced promising results in terms of increasing the use of human and material resources. The health sector in many E&E countries could be further strengthened by introducing more efficiently managed systems. Shortages of human resources, financial resource constraints, and program decentralization are all challenges that need to be addressed.

In both Romania and Armenia, organizational capacity building and management assistance have resulted in major changes in the provision of RH/FP care. In Romania in the early 1990s, the Centre for Development and Population Activities (CEDPA) began providing technical assistance to local NGOs in financial management, clinical information systems and commodity logistics, and human resource management. The NGOs also received training in management techniques from Management Sciences for Health (MSH) during the mid–1990s and from JSI beginning in 1999. JSI's technical assistance package aims to strengthen institutional capability in such areas as strategic planning, management information systems, human resources, marketing, diversification of services, and financial sustainability. In Armenia, the Armenia Social Transition Program (ASTP), working through PADCO, Inc., as the prime contractor, and PRIME II, have made important contributions to human resource development (e.g., through the development of new training curricula in RH/FP for family doctors, nurses, and midwives) and health sector workforce planning.

INTERVENTIONS FOR EXPANDING RH/FP CARE

Various approaches to promote greater access and use of RH/FP care have been supported by USAID in the E&E region. These are described briefly below.

Integration of RH/FP Care into Primary Health Care and Maternity Care

Primary Health Care

This model has been introduced in conjunction with health sector reforms that emphasize a shift from highly specialized and centralized care to primary health services supplied by general practitioners. Strengthening primary health care and integrating RH/FP is a long-term process. It requires strong leadership and political commitment at both national and local levels as well as reoriented tasks and job descriptions for service providers and health care managers.

One model that incorporates RH/FP into health care primarily is the family group practice, which represents a change from the former, highly specialized system of care, under which members of a family were required to visit different facilities to receive different types of health care. The family group practice model locates three major medical specialties (pediatrics, internal medicine, and obstetrics/gynecology) in one facility, offering integrated services on an ambulatory basis. This model has been particularly successful in the Central Asian Republics.

In Armenia and Romania, general practitioners, now called family doctors, receive basic training in RH/FP and provide integrated services, particularly in rural areas. In Kazakhstan, an effort to train family doctors in diagnosing and treating STDs through syndromic management also proved to be cost-effective when compared with reliance on dermato-venerelogy dispensaries (Riedner et al. 2000). Family doctor reforms are now being implemented at the national level in all three countries.

Efforts to strengthen primary health care facilities in the E&E region also complement efforts to make more rational use of existing health facilities and personnel. An efficiency study undertaken in the Ukraine found that primary health care reforms reduced the need for hospital care by 30 percent, secondary outpatient care by 40 percent, and ambulance

service by 30 percent. In addition, primary health care reform efforts have entailed a reallocation of more health personnel to outpatient services and fewer specialized staff to hospital care. The study also noted that more supportive client–provider partnerships resulted from the deployment of family physicians as frontline primary care providers (Lekhan 1999:13).

Maternity Care

Integration of FP counseling and services into maternity care has been a major focus in a number of selected countries in the region. In Russia, the Women and Infant Health (WIN) Project aimed to improve the effectiveness of maternal and infant health services through such interventions as exclusive breastfeeding and rooming-in. The WIN project also emphasized the training of service providers in family planning. The project design included a series of activities to train providers in contraceptive technology and counseling skills as well as the development of training curricula and information, education, and communication (IEC) materials. As a result, family planning services were effectively integrated within the context of routine antepartum, intrapartum, postpartum, and postabortion care. Other countries (e.g., the Ukraine) have not been as successful as Russia in strengthening family planning services while promoting family-centered reforms in maternity care.

Creation of Women's Wellness Centers

Another model for expanding the availability of RH/FP care has been the creation of Women's Wellness Centers (WWCs) to provide comprehensive health care services for women at all stages of their lives. The American International Health Alliance (AIHA) pioneered this approach and created more than 30 WWCs in 11 E&E countries between 1998 and 2003 (AIHA 2004:4). In 2003, additional WWCs were opened in Kazakhstan and the Ukraine. U.S.–based partners provided technical support, training, and equipment to the centers. As of the end of 2003, AIHA graduated 21 centers, while others continue to receive AIHA funding. In countries in which AIHA support has been phased out, most centers have been transferred to the public health system.

WWCs have been established to address a wide range of issues regarding women's health. However, because of their limited geographic coverage, WWCs have had modest impact on national-level RH/FP care provision. For example, Romania and Kazakhstan have only one urban-based WWC that serves limited catchment populations. In Armenia, there has been a broader impact since AIHA's main WWC in Yerevan is affiliated with several regional facilities modeled on the WWC concept.

Some USAID Missions have curtailed funding for WWCs on the grounds that they are independent, vertical facilities that are not well integrated with national health delivery systems. The high costs of establishing the centers and their low potential for national impact has also been a concern. However, many of the centers have survived and have become part of national public sector delivery systems. WWCs have also become important centers for training RH/FP providers, and some are beginning to develop telemedicine capabilities with U.S. partner institutions.

Social Marketing of Contraceptives

The social marketing of contraceptives, an approach to expand the availability of contraception through commercial outlets, has been implemented in such E&E countries as Romania, Russia, and Kazakhstan. In the early 1990s, most efforts focused on nurturing an almost nonexistent private sector for pharmaceutical products. Social marketing projects were then implemented in countries where necessary policy, regulatory, and marketing environments were established.

The Social Marketing for Change (SOMARC) project took the lead in Kazakhstan and Uzbekistan during the 1990s, and local pharmaceutical manufacturers and retail pharmacies were privatized as early as the mid–1990s. Although support for the social marketing program ended several years ago, commercial sales of condoms and oral contraceptives continue to increase and pharmacies now typically offer a broad selection of these methods. In addition, contraceptive brands introduced as part of early social marketing efforts have often continued to generate greater sales growth and larger market shares after direct donor support phaseout.

While social marketing has been successful in several countries, there are also inherent limitations to this approach. Social marketing has been most successful in increasing the availability of supply methods (condoms and oral contraceptives), but less effective for other methods (IUDs and injectable contraceptives), possibly due to the low perceived demand for these methods. Small potential markets for family planning commodities in some E&E countries may have also inhibited the growth of social marketing. For example, doubts have been raised about the feasibility of social marketing becoming an effective approach for ensuring contraceptive security in Armenia, given the small size of the country's potential commodity market (see Sulzbach et al. 2002:17).

In some E&E countries, donor support for free contraceptive distribution may have actually inhibited the expansion of commercial marketing. However, as donor commodity procurement budgets fall throughout the region, it seems likely that a greater reliance will need to be placed on commercial distribution. However, a substantial number of clients in the E&E region currently cannot afford to pay for contraceptives. This situation will require creative solutions that emphasize subsidized provision for more vulnerable populations and commercial distribution for those better able to pay for their contraceptive needs.

Population Services International (PSI) has also implemented successful condom social marketing projects in Russia, Romania, and the Central Asian Republics with funding from USAID. PSI's activities are designed to stimulate increased condom use through the distribution of high-quality, low-cost condoms for the prevention of STIs and HIV/AIDS transmission, employing targeted approaches for high-risk groups, and using nontraditional outlets to make condoms more easily available.

Specifically Tailored Youth Services

Since young adults now become sexually active at earlier ages and increasingly outside marriage, they are at high risk for having unintended pregnancies. There have been few USAID–supported activities in the region oriented toward meeting the special RH/FP needs of adolescents. SEATS supported RH/FP pilot initiatives in Albania and Russia

that were specifically tailored to youth. These program interventions demonstrated that the special needs of adolescents for information on sexuality and access to clinical services were not being met by existing adult-oriented facilities (Newton 2000). SEATS demonstrated that when programs are specifically tailored to adolescents, they can be effective in reaching this underserved group. Key ingredients in successful adolescent pilot programs included private client counseling services, teaching abstinence and delay of sexual debut, confidential service delivery, the provision of broad contraceptive method choice, and provider commitment to reproductive rights for youth. The integration of STI services into adolescent RH/FP care was also important in attracting younger clients, most notably sexually active adolescent males.

A model program was also undertaken in Romania, where USAID has supported an indigenous NGO, YfY, whose mandate is to provide RH/FP care tailored to youth. YfY's goal is to improve the health and welfare of young people under age 25 through education on issues of sexuality, family planning, and STI/HIV prevention based on a youth-to-youth communication and services approach. In addition to broad-based peer education and counseling programs through schools and campaigns, YfY operates youth centers designed to meet young people's medical counseling and family planning needs.

Another successful model designed to serve youth is found in Russia, which is supported by the United Nations Children's Fund (UNICEF). In the late 1990s, UNICEF began supporting a number of medical centers specifically tailored to youth as part of its Young People's Health and Development Program. These centers offer counseling and practical assistance to young people in matters of reproductive and sexual health, including treatment and prevention of STIs. The centers also make it easier for adolescents to obtain counseling on abstinence and delay of sexual debut as well as printed materials on the dangers of high-risk sexuality and reproductive behavior and the use of contraceptives.

Postabortion Family Planning

Even though abortion continues to be an ongoing public health issue throughout the region, there are few services that address the RH/FP needs of women who recently had an abortion. In E&E countries, abortions are usually provided by obstetricians/gynecologists either at public hospitals or, increasingly, at private facilities. However, many women are discharged after having an abortion without receiving RH/FP counseling or care.

In 2000, EngenderHealth and the Population Council investigated the impact of high-quality, postabortion FP care on the repeat abortion rate and continued use of contraceptives in Russia. Although the long-term results of this intervention cannot be determined, the initial phase of the study showed that postabortion counseling did make an important difference. Postabortion clients were more likely to use family planning if the contraceptive of their choice was provided before they left the health facility. Two independent pilot projects (not funded by USAID) in Romania are exploring similar approaches to providing family planning and postabortion counseling to women.

BEHAVIOR CHANGE COMMUNICATION (BCC)

Over the last decade, mass media campaigns have been implemented in many countries with collaboration from the Population Communication Services program of Johns Hopkins University (JHU/PCS). These activities have often been implemented in conjunction with project initiatives oriented to upgrading provider skills and expanding RH/FP care. The most prominent are the following:

- Armenia: Green Path Campaign,
- Georgia: Care for Each Other Family Health Campaign,
- Romania: Women's Reproductive Health Program,
- Russia: Healthy Russia 2020,
- Russia: Women and Infant Health Project (WIN),
- Russia: Care for Health, and
- Ukraine: Postpartum/Postabortion Family Planning Initiative.

These BCC campaigns typically use modern mass media channels as well as promotional activities built around logos, slogans, and informational materials. Site-specific surveys have also been conducted that have shown that mass media messages have often been successful in motivating couples to access and use family planning services. This impact appears to have been most successful when linked to the provision of services. However, it is difficult to assess the overall impact of these campaigns on a national basis. In some cases, BCC campaigns do not appear to have been sharply focused and have studiously avoided the issue of abortion. Among the local area project-specific results that can be cited are the following:

- Armenia: The use of contraception increased 4.6 percent in target regions, and 61 percent of these FP clients reported that they were prompted to visit by media messages.

- Georgia: Contraceptive use in Tbilisi rose from 25 percent in 2000 to 37 percent in 2002. The percentage of married women in Tbilisi that had an abortion fell from 45 percent in 2000 to 28 percent in 2002.

- Romania: Modern method use rose from 39.3 percent to 42.6 percent during a 4–month national media campaign, and clients reported more favorable attitudes toward family planning.

- Russia: Exposure to family planning messages in the WIN project areas increased in intervention areas and coincided with gains in modern method use and lengthened durations of breastfeeding.

- Russia: The Care for Health Project generated gains of 12 percent in modern method use and longer durations of use in target regions.

- Ukraine: Visits to family planning centers during postpartum and postabortion periods increased 200 percent following BCC interventions. Strategies emphasizing partner communication proved effective in promoting knowledge and use of family planning methods.

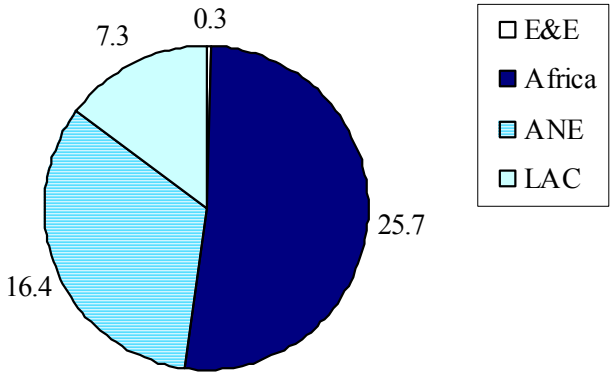
In recent years, BCC activities have shifted more toward using communication channels at the community level, emphasizing interpersonal communications with an emphasis on increasing awareness of RH/FP care as well as promoting healthier RH/FP practices. The Romania Family Health Initiative (RFHI) project, for example, has used more interpersonal communications. Interventions have focused on training service providers and counselors, distributing materials during community meetings, giving factory presentations, and providing counseling sessions. The Romanian project has also worked to ensure that BCC activities are closely coordinated at the local level with service delivery and capacity-building efforts. This seems to be a key strategy for increasing the effectiveness of BCC program elements.

Another innovative BCC practice from the Ukraine that should be considered for replication elsewhere in the E&E region is the emphasis given to enhancing partner communication in promoting knowledge and use of family planning methods (Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs [JHU/CCP] 2004:1–4). Tailoring BCC activities and messages for couples rather than individual women (which was standard practice in the early days of international family planning programs) resulted in increased contraceptive use and increased male involvement in supporting reproductive health and family planning.

CONTRACEPTIVE SECURITY

USAID has not had a strategy for supplying contraceptive commodities in the E&E region, although contraceptive support was provided for some countries under individual projects in the past. Currently, USAID–funded projects provide very little contraceptive support. As can be seen in figure 7, USAID/E&E was awarded less than 1 percent of USAID's total contraceptive commodity budget in FY 2002.

Figure 7
USAID Contraceptive Funding by Region
(FY 2002)



Until recently, UNFPA was the main source of donated contraceptives. However, its contraceptive support has not been strategically focused or continuous. Rather, UNFPA supplied significant quantities of contraceptives to some countries on an ad hoc basis as funds from international donors became available. For example, UNFPA provided large quantities of contraceptives procured through Department for International Development (DFID) funding to Romania and Kazakhstan. UNFPA has currently ended contraceptive

support to most E&E countries and does not have plans to continue providing contraceptives unless additional international funding can be secured.

Following the cessation of UNFPA support for contraceptives, many E&E countries began experiencing contraceptive shortages, and public sector stock-outs have become increasingly common. In response to this situation, USAID country programs have begun putting increased emphasis on supporting sustainable activities to help countries assume ownership of their family planning programs, including the future procurement of contraceptive supplies and strengthening contraceptive logistics systems and budget tracking. Such initiatives will help guarantee contraceptive security.

In the past, the program in Turkey worked with local partners and other donors to ensure a sustainable supply of contraceptives. Between 1996 and 2000, USAID and the Turkish Ministry of Health (MOH), with technical assistance from the POLICY Project, implemented a contraceptive self-reliance project that aimed to phase out USAID contraceptive donations while the MOH took over the entire responsibility of managing its contraceptive supplies. The goal of the project was achieved by 2000 through training assistance for budget requirements and allocations, procurement and service targeting, and contraceptive logistics management. More recently, the Romanian government has begun procuring contraceptives to ensure that vulnerable populations have access to free or subsidized contraceptives; it has been increasing its contraceptive procurement budget since 2001.

However, for the majority of countries in the region, government programs cannot purchase and deliver enough contraceptives to meet demand, and the problem is worsening as funding becomes less reliable. In the Ukraine, for example, the national budget has no funds for contraceptives and there are no procurement plans for meeting future needs. Similarly, Azerbaijan and Georgia do not have contraceptive security strategies even though both countries have inordinately high abortion rates. If contraceptives cannot be readily procured and distributed, family planning programs will not succeed.

IV. BEST PRACTICES IN REPRODUCTIVE HEALTH AND FAMILY PLANNING IN THE EUROPEAN AND EURASIAN REGION

This assessment has identified a number of best practices in RH/FP that have been successfully implemented in the E&E region. Best practices refer to those approaches that maximize the quality, efficiency, and effectiveness of RH/FP care. Although a widely used term, there is no universally accepted definition of what constitutes a best practice. For the purposes of this review, the team specifically looked for field evidence and focused on the following characteristics in selecting best practices:

- improve RH/FP,
- can be made sustainable,
- have potential for replication,
- are innovative, and
- are best tailored to meet local needs.

INTEGRATION OF RH/FP WITH PRIMARY HEALTH CARE IN CONJUNCTION WITH HEALTH CARE REFORM IN ARMENIA AND ROMANIA

In Armenia, the PRIME II project has developed an RH/FP training module for the country's newly formulated unified family medicine curriculum. This initiative has been instrumental in equipping family doctors with new RH/FP competencies in the project area of Lori Marz. The project has worked to improve provider knowledge/skills and to strengthen the quality of RH/FP service provision. This was done through innovative self-paced instructional materials and participatory training that stressed clinical practice rather than theory. Family doctors and obstetricians/gynecologists were the main providers trained by the project. In addition, nurses and midwives based in remote rural health posts also received instruction from the project and were linked more effectively into the health system's referral network.

The ability of the PRIME II project to address RH/FP competencies at different levels of Armenia's health system constitutes a best practice that should be considered for replication in other E&E settings. This work, which has been a key element of USAID's ASTP, is scheduled to continue through a new Technical Assistance and Support Contract (TASC) II contract awarded to the Emerging Markets Group.

The Romania Family Health Initiative (RFHI), implemented by JSI's Research and Training Institute, Inc., is working to increase access and use of RH/FP care nationwide and to improve and integrate services at the primary health care level. To this end, the project supports the MOH and a number of NGOs in capacity-building efforts to improve the effectiveness of family planning and selected RH care for underserved populations.

The project implements a multipronged approach to accomplish its goals.

- RFHI works closely with the Romanian MOH to create an enabling policy environment to improve access of RH care as part of health sector reform efforts. The project has been instrumental in the development of the country's

National Sexual and Reproductive Health Strategy that was adopted by the MOH and disseminated nationally.

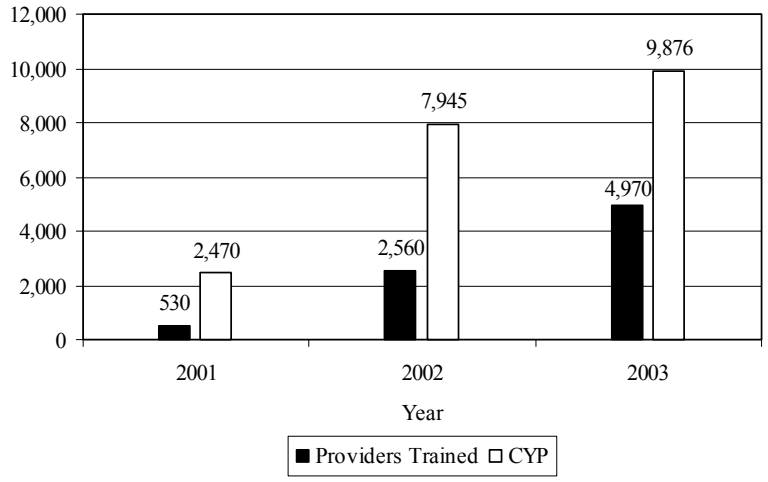
- Within the MOH's national program, the project provides technical assistance to ensure contraceptive security and improve the provision of family planning services at selected service delivery points.

- Assistance provided for the development and use of the logistics management information system has improved the management of contraceptive commodities at the national and district levels.

- An increasing emphasis has been placed on adolescent reproductive health through BCC campaigns that provide information on abstinence and delay of sexual activity intended for at-risk youth, including high school visits to provide information to students on RH/FP and providing street children with RH counseling services.

- RFHI led efforts for the development of service delivery standards and training curricula for family planning and related RH/FP care. As of the end of 2003, more than 2,300 general practitioners and 1,750 nurses were trained in basic family planning. Family planning use also rose substantially, with couple years of protection (CYPs) rising nearly 300 percent between 2001 and 2003 (see figure 8).

Figure 8
Number of Providers and Couple Years of Protection in Romania
(2001–2003)



- At the same time, public sector service expansion coupled with social marketing programs have led to a doubling of modern contraceptive users in RFHI's original 18 project areas. The RFHI program has now expanded from 18 to all 42 districts in the country. This social marketing initiative was successful in expanding the use of contraceptives in urban areas through commercial outlets while allowing for the free provision of contraceptives through public facilities in less prosperous rural settings.

STRENGTHENING NGO INVOLVEMENT IN RH/FP CARE IN ROMANIA

In the early 1990s, USAID began supporting the newly emerging NGO sector in Romania through CEDPA. Two new NGOs were established with technical support from CEDPA: the Society for Education on Contraception and Sexuality (SECS) and the Youth for Youth Foundation (YfY). CEDPA's programs were designed to create service models for the provision of preventive health care for women. Initial activities involved training programs in leadership, advocacy, and institution building; expanded service delivery through strengthened leadership and participation; and increasing opportunities for young women to broaden their life choices.

NGOs in Romania have been instrumental in providing RH/FP information and care and constitute a best practice in promoting effective public and private sector partnerships. The government of Romania became more involved in RH/FP initiatives by the mid–1990s due to pressure from the NGO sector and strong partnerships between public and private sector providers. Currently, NGOs have a leading role in many aspects of the RH/FP program and continue to receive assistance from USAID as well as other international agencies. SECS focuses on increasing public awareness of women's reproductive health and rights and in advocating for improved service delivery standards through model clinics and the training of health personnel. The MOH relies entirely on SECS for its staff training. YfY has become a national NGO with 30 branches in 11 districts providing adolescent RH/FP education and care. YfY uses innovative approaches to reach youth, including educational programs for high school adolescents, such as computer games that promote healthy lifestyles.

Both organizations rely on the work of volunteers in addition to their core professional staff. It is noteworthy that both have begun providing technical support to neighboring countries. For example, the curricula developed and used by YfY for training volunteer counselors in RH/FP has been exported to Bulgaria, Moldova, and Albania. Similarly, SECS has been providing RH/FP training for providers from Bulgaria and Moldova. While neither organization has achieved financial sustainability, they have matured in terms of institutional and technical capability.

In addition to these two pioneer NGOs, two others have benefited and continue to grow as they receive support from USAID and other international agencies: the Romanian Association Against AIDS (ARAS) and the East European Institute for Reproductive Health (EEIRH). Founded in 1996, EEIRH promotes sexual and reproductive rights and contributes to expanding RH/FP policies by raising public awareness in Eastern European countries.

POSTABORTION PROGRAM SUCCESS IN TURKEY

In the early 1990s, it was evident that many Turkish women were still relying on repeat abortions to control their fertility. The public sector family planning program, despite its successes, was unable to meet all the contraceptive needs of these women. Clients who had abortions had limited access to family planning information and services. In response to this need, the Turkish MOH initiated a postabortion family planning program in the early 1990s to improve FP services in 10 government facilities where substantial numbers

of abortions were provided. The program was supported by USAID, with technical assistance from AVSC International (now EngenderHealth).

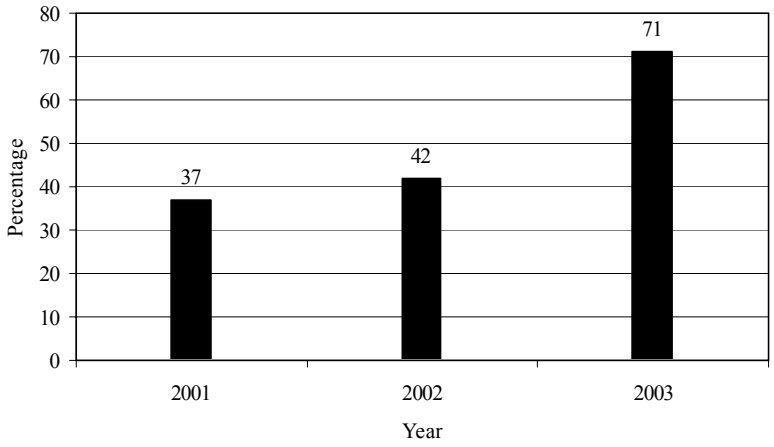
Before these interventions, hospitals did not routinely offer postabortion family planning. The postabortion project was implemented through a three-pronged approach by

- overcoming staff resistance to providing postabortion family planning counseling and services,
- providing accurate information to abortion clients about family planning, and
- expanding method choice.

Within only two years, the use of modern contraceptives among abortion clients increased at most project sites.

As can be seen in figure 9, the percentage of postabortion women adopting family planning rose from 37 to 71 percent between 2001 and 2003. The program also succeeded in providing a wider range of contraceptive methods. Furthermore, the annual number of abortions provided at project hospitals began to decrease over the following years. The MOH has continued to expand postabortion FP after USAID support ended for the project in the late 1990s, and provision of family planning services and counseling to abortion clients has become routine in government facilities in Turkey. This model could easily be replicated in other E&E countries with inadequate postabortion RH/FP counseling and care.

Figure 9
Percentage of Postabortion Women Adopting Family Planning in 14 Clinics in Turkey



CONTRACEPTIVE SOCIAL MARKETING IN KAZAKHSTAN

USAID began funding contraceptive social marketing in Kazakhstan in 1993 (using the Red Apple logo) through the SOMARC project. The objective of the activity was to develop a sustainable commercial retail market for contraceptive pharmaceuticals that would provide an easily accessible alternative to abortion. At that time, the government-owned central pharmacy, Farmatsyia (an importer, distributor, and retailer of drugs)

dominated the pharmaceutical market. Developing a viable, private pharmaceutical sector was the main challenge for the program.

The project initially forged partnerships between five international manufacturers and local distributors to sell six brands of oral contraceptives, two injectable contraceptives, and one type of condom. JHPIEGO trained RH/FP providers while SOMARC led advertising, market research, and public relation efforts.

In 1995, 92 percent of all couples received contraceptive supplies from a public facility. As of 1999, the public sector accounted for 76 percent of all contraceptives and the commercial sector contributed an additional 20 percent of total supply. However, there was wide variation among the methods provided. The public sector was the main provider of IUDs (86 percent), while the commercial sector provided most oral contraceptives (71 percent) and condoms (64 percent). Given the virtually nonexistent market for contraceptives at the beginning of the decade, this commercial sector expansion was significant.

At the time of this assessment, Schering was marketing five brands of combined low-dose oral contraceptives and dominated 70 percent of the oral contraceptive market. Schering representatives were satisfied with their growth in sales, which steadily increased over the last decade (doubling annually since 1998). However, the company has discontinued marketing of the injectable contraceptive Depo-Provera due to the lack of market growth. Currently, several brands of oral contraceptives and condoms are available at private pharmacies in urban areas.

A client hotline was established in Kazakhstan by the SOMARC project from which clients can obtain accurate and updated information about RH/FP products and care. Initially housed in Almaty, the hotline functioned on a national basis. Later, the hotline was decentralized by opening local offices in eight cities. This decentralization significantly reduced the cost of the hotline and allowed for the provision of more specific advice on local facilities and services. The hotline, which is both convenient and anonymous, has proven to be an effective approach for supplying up-to-date information to consumers on contraceptive options and services as well as on basic reproductive and maternal health issues.

USAID has continued to provide support for the hotline while the local NGO (Business Women's Association) works to secure resources from other donors and local businesses to continue the service. This inexpensive but easy-to-use service could easily be replicated in other E&E countries. USAID–supported hotlines have also proven to be effective in dealing with domestic violence, sexuality, and reproductive rights issues. A good example is the Armenia hotline operated at Polyclinic 8 in Yerevan that deals with violence against women (a major problem in Armenia that until now has received little concrete programmatic attention).

INTEGRATION OF FAMILY PLANNING INTO FAMILY–CENTERED MATERNITY CARE IN RUSSIA

USAID–funded programs have been instrumental in promoting family-centered maternity care reforms in several countries in the E&E region. This effort has focused on introducing new evidence-based practices that simplify and demystify the natural process

of childbirth. Best practices that have resulted from these initiatives include rooming-in for mothers and infants, increased participation of husbands and other immediate family members as caregivers, exclusive breastfeeding, provision of family planning counseling and services, reduced use of drugs for inducing labor, strengthening of infection control procedures, and diminished reliance on such surgical procedures as Caesarean sections and episiotomies.

One of the more notable efforts to introduce family-centered maternity care occurred in the WIN project in Russia. This project, implemented by JSI, JHU/PCS, and EngenderHealth was implemented in three pilot sites (Perm, Berezniki, and Novgorod) and emphasized training in evidence-based medicine and quality assurance methods, client-centered approaches to RH/FP care, improved communication between health care providers and clients, and the promotion of preventive health practices.

The project achieved remarkable success within five years in reforming maternity care practices and integrating family planning and maternity services in three oblasts. A midproject evaluation noted that maternal and infant health improved dramatically within the first 18 months of the project following the introduction of new maternity practices (Kantner, Rooks, and Jordan 2001). By the end of the project in 2003, clinic data maintained by the project indicated that abortion rates had fallen in all three project sites (see figure 10 on the following page) as the use of modern contraception rose (see figure 11 on the following page) (John Snow, Inc. 2003c). Repeat abortions in Perm Oblast (one study area for WIN) fell by 12.9 percent after providing postabortion family planning counseling and by 13.8 percent when counseling was combined with the provision of a contraceptive method (although the study's control group registered an even larger 18.4 percent decrease in repeat abortions over the two-year period of the study) (Savelieva et al. 2003:23). This intervention could easily be replicated elsewhere in Russia. Major declines in upper respiratory infections, pneumonia, jaundice, and ear infections among infants were recorded. In addition, major cost savings were achieved by reducing the average length of hospital stays and expenditures on sterile suture materials, analgesic and anesthetic drugs, baby formula, antibiotics, and intravenous solutions.

By 2003, family planning counseling and service provision had been effectively institutionalized within the three pilot sites participating in the project (Perm, Berezniki, and Novgorod), including women's consultation centers, maternity hospitals (including delivery and postpartum departments), and polyclinics. The RH/FP training offered to service providers in project sites was later replicated within other oblast facilities. This successful pilot project has recently been expanded to 10 regions (in addition to the initial two project sites) as part of the new Maternal and Child Health Initiative Project implemented by JSI. Future RH/FP training activities will be undertaken through Russian government agencies, professional associations, and NGOs. This best practice model should be considered for replication in other E&E countries since high maternal morbidity and mortality remains a major concern throughout much of the E&E region.

Figure 10
Abortion Rates for Women Ages 15–44 in Perm, Berezniki, and Novgorod, Russia
(January 1997–December 1999 and July 2000–February 2003)

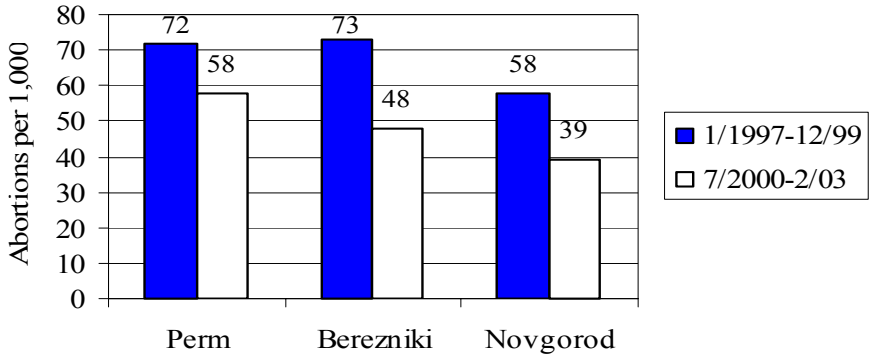
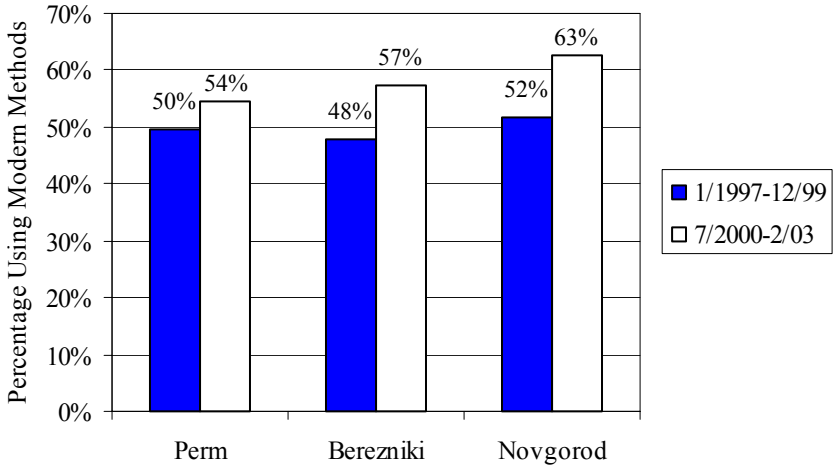


Figure 11
Percentage of Currently Married Women Using Modern Contraception in Perm, Berezniki, and Novgorod, Russia
(January 1997–December 1999 and July 2000–February 2003)



COMMUNITY INVOLVEMENT AND OUTREACH IN ARMENIA

The PRIME II Project in Armenia, in collaboration with Save the Children, has piloted a successful community mobilization effort to enhance awareness and knowledge of local reproductive and child health needs. Community action councils were created in 20 local areas that engaged community leaders, private citizens, and health providers in identifying health conditions and priority service requirements. Fourteen councils are now providing social insurance to poorer households that otherwise could not afford health care and have raised resources for upgrading the physical infrastructure of existing health centers and informing local populations about these enhanced facilities.

Much of USAID's support for RH/FP programs has focused on enhancing the accessibility and quality of clinical services. While this focus is essential, it is also critical that communities become more involved in RH/FP activities. These efforts should include advocacy and education programs to promote reproductive health and rights,

efforts to encourage greater health-seeking behavior through community-based counseling and information campaigns, and the adoption of healthy lifestyles based upon sound preventive health practices. Without greater community awareness and involvement in RH/FP programs, there is a serious danger that health facilities will be underused and clients underserved.

In Armenia, the need for greater community participation is obvious. Women often do not have essential information on family planning and reproductive health. They also tend to be uncertain about where to obtain reproductive health care and unclear about the range of services offered in polyclinics or rural ambulatory centers. The fact that pregnant women tend to obtain prenatal care late in their pregnancies—often not until the third trimester—suggests a need for greater community education and service outreach.

There is also some concern that USAID programs may have been placing too much emphasis on upgrading curative and clinical services and not enough on community-based programs emphasizing disease prevention, nutrition, healthy lifestyles, and the availability of care. A major, future challenge that senior health officials noted in both Armenia and Kazakhstan is how to best change the mindset of the population to be more conscious of health needs, overcome mistrust of health providers, and make greater use of available health services.

INTEGRATION OF SEXUALLY TRANSMITTED DISEASE PREVENTION AND CARE INTO FAMILY GROUP PRACTICES IN KAZAKHSTAN

A pilot program in Zhezkazgan, Kazakhstan, in which family doctors were trained in diagnosing and treating STIs (e.g., gonorrhea and symptomatic syphilis) proved successful (Riedner et al. 2000). The project demonstrated that family doctors could provide quality STI care at a lower cost than by relying exclusively on more specialized dermato-venereology dispensary service sites. Family doctors were also able to gain the trust of young clients.

The ability of family doctors to provide STI diagnostic and treatment services was considerably enhanced following training, especially in the management of urethral discharge and genital ulcer. However, family doctors were not well prepared to conduct microbiological STI testing, which led to some overtreatment of cervicitis. Collaboration with local dermato-venereology dispensary facilities (in training and supervision) was found to enhance the accuracy of diagnosis and client satisfaction. This model would be a good candidate for further expansion and replication, especially in E&E countries with high infertility resulting from undiagnosed and untreated STIs.

DEVELOPMENT OF NEW RH/FP STANDARDS AND PROTOCOLS IN ARMENIA, KAZAKHSTAN, AND ROMANIA

USAID–supported programs have had a major role in developing and implementing new standards and protocols for providing RH/FP care in the E&E region. Good examples are found in Armenia, Kazakhstan, Romania, Turkey, and the Ukraine. These activities were originally initiated in many E&E countries through JHPIEGO training programs, but more recently have been advanced by other USAID–funded projects and cooperating agencies, such as PRIME and JSI, and other donor organizations, such as UNFPA. Many

of these new practices have been officially adopted by ministries of health as replacements for Soviet-era procedures. For example, the Armenian government is now in the final stages of approving new regulations pertaining to the safety and quality of maternal and child health care. These regulations will require the adoption of new, internationally accepted standards on infection prevention, client-centered care, and more efficient organization of services.

The new standards and protocols that are being introduced throughout the region address family planning (including client counseling), the management of reproductive tract infections and sexually transmitted diseases (including HIV/AIDS), antenatal care, delivery services, postpartum and newborn care, and infection prevention. Client-centered quality of care issues, such as privacy, confidentiality, and respect, are also featured. The new standards and protocols are clear and concise, with easy-to-follow instructions relating to various client needs, diagnostic contingencies, and treatment options. In Kazakhstan, USAID and UNFPA have been encouraging the adoption of 39 evidence-based clinical protocols (based on World Health Organization [WHO] recommendations) for providing RH/FP care in government polyclinics and maternity hospitals.

Training in new practices is commonly conducted for obstetricians/gynecologists, family doctors, nurses, and midwives. International, national, and regional experts typically provide this training through a combination of formal instruction, clinical practice, and the use of new self-paced learning materials. To meet the E&E region's growing instructional needs, new training programs and facilities have been developed. These efforts constitute a major contribution to improving the quality of RH/FP care and may well be USAID's most important health initiative in the region.

V. LESSONS LEARNED AND RECOMMENDATIONS

IMPORTANT PRECONDITIONS FOR RH/FP PROGRAM SUCCESS NEED TO BE ACKNOWLEDGED

The level of RH/FP program development varies considerably within the E&E region. In general, the Central Asian countries constitute the most developed subregion, although variations exist among countries. Eastern European countries have made somewhat less progress, although such countries as Romania are exceptions. The Caucasus countries lag behind the other E&E subregions. For example, Georgia and Armenia are still far from having sustainable RH/FP programs.

A number of interrelated elements were identified that have helped some countries achieve greater gains in RH/FP over the years.

The Socioeconomic Status of the Country

Following the breakdown of the Soviet Union, there have been variations among countries in terms of economic growth. Countries with rich resources have made substantial investments in health care as well as in other sectors, while resource poor countries are still struggling with economic instability. It is not realistic to expect that all countries would be able to invest equally in health care, particularly in RH/FP, regardless of the external support they have received. Overall economic growth has enabled resource rich countries (e.g., Kazakhstan) to achieve more in RH/FP. Resource poor countries (e.g., Armenia and Georgia) were not able to invest substantially in RH/FP over the last decade.

Level of Government Commitment to RH/FP

Governments differ in terms of their commitment to improve the RH/FP environment. In some countries, declining population size is a major concern (e.g., Georgia, Armenia, and the Ukraine) and decision-makers seem to overlook RH/FP issues in favor of their desire to encourage higher fertility. While USAID–supported policy dialogues have helped government appreciate the importance of family planning, some E&E countries have still not given a high priority to RH/FP.

The Commitment of USAID Missions to RH/FP

Those countries in which USAID Missions implemented clear, consistent, and continuous strategies to support RH/FP programs have made more progress. This commitment to RH/FP programming has varied considerably within the region. For example, it appears that USAID/Romania puts a much higher emphasis on RH/FP than does USAID/Ukraine.

Involvement of the Commercial and NGO Sectors in RH/FP

The level of development of nongovernmental institutions and their involvement in RH/FP also varies greatly across the region. Those countries in which viable and dynamic commercial and/or NGO sectors are involved actively in RH/FP programs have made

more progress compared with those in which RH/FP is still largely a public sector initiative.

Integration of RH/FP Care into Primary Health Care and Maternity Care Services

Many E&E countries are making progress in integrating RH/FP services and BCC initiatives into primary and maternity health. Nonetheless, these efforts often need to overcome regulatory barriers. For example, health reform efforts in Kazakhstan aimed at strengthening the provision of family medical services and integrating RH/FP into primary health care have been slow due to unsupportive MOH policies and regulations. In Romania, influential gynecologists still resist initiatives that allow general practitioners to provide family planning services at the primary health level.

Nevertheless, these initiatives have achieved a significant impact in certain countries and have a high potential to succeed in other countries. Integration efforts have a greater chance of success when implemented in conjunction with other health sector reforms. In contrast, vertical or independent interventions to provide RH/FP services (e.g., Women's Wellness Centers) have had a more limited impact, due mainly to issues of sustainability and replicability.

CONTINUITY OF SUPPORT IS ESSENTIAL FOR PROGRAM SUCCESS

USAID's experience in developing countries suggests that development assistance for building sustainable RH/FP programs is a lengthy and complex process. For example, RH/FP programs in such countries as Brazil, Morocco, and Turkey were only able to graduate from USAID assistance after more than two or three decades of support.

USAID's assistance to most E&E countries has been ongoing for little more than 10 years. In the early years of this involvement, many E&E country programs were not able to make much progress, due largely to the lack of commitment from governments and unfavorable regulatory and policy environments. The magnitude of the required work and time needed was underestimated in the region. Universal access to curative health services in E&E countries collapsed abruptly with the breakup of the Soviet Union. In addition, quality of care issues within the health care systems of the E&E region were not well understood in the early 1990s.

Recommendation
Continue long-term assistance for RH/FP programs in the E&E region.

It is essential that funding for RH/FP programs continue at a substantial level, particularly in selected E&E countries where abortion rates are still high and contraceptive use is low.

Priority for future USAID RH/FP assistance should be directed toward countries with high abortion and maternal mortality rates, low use of modern contraception, and high HIV/AIDS prevalence. In terms of family planning use, future priority countries tend to be clustered in the Caucasus (i.e., Armenia, Azerbaijan, and Georgia). Another priority country for RH/FP assistance is Albania, which has the lowest level of modern contraceptive use in the E&E region. USAID will also need to remain engaged in Romania, Russia, and the Ukraine, since the HIV/AIDS epidemic is more advanced in these regions. Maternal mortality rates are generally high throughout the E&E region,

with nations in the Caucasus having somewhat lower rates than in Eastern Europe and the Central Asian Republics. Recent estimates suggest that Tajikistan, Kazakhstan, Kyrgyzstan, and Russia have the highest maternal mortality in the E&E region, which suggests that future USAID projects to upgrade the quality of maternity care should include these four countries.

Even though USAID's RH/FP assistance has had a crucial role in increasing the use of modern contraception, reducing unintended pregnancies, and lowering the use of abortion, many women in these countries still lack access to modern contraception and other basic RH/FP services. Many service providers, particularly in rural areas, are still ill equipped or unable because of restrictive regulations to provide quality RH/FP care. Laboratory capacities in women's health facilities for analyzing Pap smears and diagnosing STIs often are inadequate and point to the need to train more cytologists and obstetricians/gynecologists in these skills.

GAINS IN MODERN CONTRACEPTIVE USE ARE EFFECTIVE IN REDUCING ABORTION RATES

Abortion rates are still high and modern contraceptive use is low throughout the E&E region. Modern method prevalence in most E&E countries is generally comparable to less developed nations in Asia and Africa, and abortion rates are among the highest in the world. Many women continue to use abortion in lieu of contraception. While abortions are legal in all countries of the region, this does not mean that abortions are necessarily always available and safe, especially in the Caucasus. An increasing number of abortions are performed in the private sector (many of which are underreported), and some are illegally performed by unskilled providers. Outdated techniques and inadequate infection prevention practices often result in high complication rates. As a consequence, abortion continues to be a major public health issue in the E&E region.

Recommendation
RH/FP services need to be strengthened so that more women can have alternatives to abortion.

The evidence from the E&E region is clear. When more women use effective methods of modern contraception, abortion rates usually decline. The most effective intervention for reducing abortion is to make family planning counseling and services affordable and widely available (through public health facilities, private doctors, and the commercial sector). Given the small desired family size in many E&E countries, it is likely that the demand for abortion will remain high unless modern contraception can be made more accessible.

While USAID and other donors have made a good start over the past decade, much work remains to enhance the use of modern contraception. More fully integrating RH/FP services with primary health care (both through the introduction of family doctors and family group practices) has proven to have much promise throughout the region, but will require additional time and resources to achieve national impact. Increased efforts to improve the income and working conditions of medical doctors and nurses/midwives could also help stem the growing incidence on informal, offsite abortions that serve as a source of salary supplementation.

RH/FP PROGRAMS NEED TO BE GIVEN GREATER EMPHASIS IN HEALTH SECTOR REFORM EFFORTS

In many E&E countries, family planning service provision is still weak. Contraceptive services are often not given much attention in polyclinics and maternity hospitals. Even AIHA's well-equipped Women's Wellness Centers appear to give lower priority to family planning compared with other reproductive and maternity practices. Family planning counseling is often inadequate, partly because highly specialized obstetricians/gynecologists who provide RH/FP care tend not to have good client counseling skills.

There has not been sufficient advocacy work in the region showing that RH/FP are integral components of maternal and child health. Efforts to encourage the use of modern contraception are still often seen as attempts to limit births in countries with below-replacement fertility levels and pronatalist policies.

The use of oral contraception has been stymied by the widespread perception that hormonal methods carry significant health risks and can trigger debilitating side effects. This perception dates from Soviet times, when high dose estrogen pills were the only hormonal contraceptives available in many E&E countries. In addition, in the early post-Soviet years, injectable contraceptives were sometimes dumped on local markets with little effort to educate providers and clients about the potential benefits of the method. Currently, IUDs are increasingly difficult to find in some E&E countries (e.g., Armenia and Kazakhstan). Norplant has not been promoted widely and is usually not available. In addition, male and female sterilization services are almost nonexistent (tending only to be offered by specialized medical facilities in urban areas with severe restrictions) and have not been extensively promoted as safe methods for couples wishing to cease childbearing.

Recommendation
Promote RH/FP care as an essential component of women's health programs.

RH/FP care should be promoted as an essential element of women's health care throughout the E&E region. The importance of the links between RH/FP for maternal and child health, adolescent health care, and male reproductive involvement have not been sufficiently explored. All too often, RH/FP care supported by international donors have been viewed by governments and the popular media largely as efforts to lower fertility rates and restrict the use of abortion.

SUCCESSFUL RH/FP PILOT PROJECTS WILL HAVE LIMITED IMPACT IF THEY CANNOT BE REPLICATED AND EXPANDED

Many RH/FP activities supported by USAID in the E&E region have been demonstration projects situated in selected subregions and local communities. To date, social marketing programs are the principal USAID–supported efforts that have had a significant national-level impact. However, there is considerable potential for successful pilot projects promoting best practices to have a larger national and regional impact. This will require that USAID and other donors give greater consideration to future resource needs and design newly expanded programs to be more financially sustainable.

Recommendation
Replicate and expand successful RH/FP pilot interventions where feasible.

A number of models implemented by USAID–funded projects have been successful in improving RH/FP service availability and accessibility. The following approaches should be further supported and expanded.

Integrate RH/FP Care With Primary Health Care

In many E&E countries, the restructuring of primary health care services is well underway as part of health sector reform. Integrating RH/FP with primary health care services during this process is an effective way to expand service availability and accessibility, and is also important for expanding services in rural areas, where general practitioners are the main providers of health care. Strengthening primary health care and integrating RH/FP into these services is a long-term process; it requires strong leadership and political commitment, policy changes that allow family doctors to provide family planning counseling and services, and reorientation of service providers and health care managers. In many E&E countries, family doctors could be trained in more areas and provide a broader range of services (e.g., IUD insertions and STI diagnosis and treatment). Licensing of family doctors could also be made more efficient in many E&E countries. In addition, advocacy efforts on behalf of RH/FP integration with primary health care should be strengthened in professional family doctor and midwife associations.

Integrate RH/FP Care With Family-Centered Maternity Care

The integration of RH/FP counseling and care into maternity care projects funded by USAID is also a potentially powerful approach. However, the integration of RH/FP care within efforts to reform maternity care has not been a focus in many E&E countries, other than Russia. USAID should encourage replication of the Russian WIN project model, in which RH/FP care and counseling are successfully integrated within the context of reformed antepartum, intrapartum, and postpartum care.

Increase Support for Postabortion FP Services

Experience in countries such as Russia and Turkey has demonstrated that postabortion RH/FP care is an effective way to change women's attitudes about abortion and the use of contraception. Unfortunately, only a few E&E countries have explored the feasibility of integrating postabortion care with family planning services. Women undergoing abortions mostly leave health facilities without receiving family planning services and counseling, although experience indicates that the best opportunity to influence women undergoing abortion is immediately following the abortion. More support for postabortion counseling and care is essential, especially in countries thought to have rising levels of unsafe abortion in the informal (unofficial) health sector.

Work to Make Women's Wellness Centers More Sustainable and Integrated with National RH/FP Delivery Systems

Women's Wellness Centers (WWCs) provide comprehensive health care services at a single location for women at all stages of their lives. However, the high costs of

establishing the centers and their uncertain potential for national-level impact makes them difficult to replicate without external funding. In addition, the maintenance of existing centers has been difficult. Many centers have growing maintenance problems (e.g., arising from degrading medical equipment that governments often cannot afford to replace). USAID should also work with AIHA to make the WWC model more financially sustainable than it is. In countries in which USAID will be providing continued support for WWCs, steps should be taken to ensure that family planning counseling and services are prominent components of the comprehensive RH care being offered by these centers.

Give Increased Priority to Services Specifically Designed for Youth

In many E&E countries, RH/FP information and care specifically designed for youth are not being given sufficient priority. It is often assumed that family doctors providing basic RH/FP care in mixed polyclinic settings can attend to the needs of young adults as effectively as other age groups. This is a questionable assumption, especially with respect to the RH/FP needs of sexually active, unmarried adolescents. It is quite understandable that adolescents wanting access to RH/FP counseling and care might be reluctant to consult a family physician who treats other family members in mixed polyclinic settings, since confidentiality cannot be ensured.

Only a few successful interventions serving the needs of young adults and adolescents were identified during this assessment. One notable exception was the Youth for Youth program in Romania. USAID should give increased priority to promoting RH/FP interventions specifically directed toward the needs of young people (especially sexually active adolescents). NGOs may be best positioned to provide such focused and sensitive care.

RESOURCE CONSTRAINTS AND WEAK COMMODITY LOGISTICS MANAGEMENT ARE IMPEDING THE EXPANSION OF RH/FP CARE

Comprehensive RH/FP care cannot take root in the region without plentiful and reliable supplies of contraceptives. As donors reduce their procurement support, contraceptive security looms as an urgent issue. Many E&E governments have still not taken steps to procure adequate supplies of contraceptives for their health systems. While the commercial distribution of oral contraceptives and condoms has grown substantially, there are still serious concerns with respect to affordability as well as uncertainties pertaining to the geographic coverage of social marketing products. Most countries in the region still do not have steady supplies of low-cost, high-quality condoms.

Nonetheless, several governments in the E&E region are now taking steps to increase budgets for the direct procurement of contraceptives. For example, the government of Armenia is planning to greatly increase its budget support for contraceptives in the coming year. However, in most if not all countries in the region, public sector logistical management systems for procuring and distributing contraceptives and other RH/FP supplies are often poorly managed and maintained. Additional donor assistance will likely be required in order to strengthen commodity distribution mechanisms as governments take on greater budgetary responsibility for addressing the commodity and equipment needs of their health systems.

Recommendation
Promote increased contraceptive security in the E&E region.

In the E&E region in recent years, donor support for contraceptive procurement has fallen dramatically. Both USAID and to a much greater degree, UNFPA, have been phasing out funding for contraceptive commodities. These reductions have compromised the reliable supply of contraceptives, particularly through public sector polyclinics and maternity hospitals. Governments need to take greater responsibility for procuring necessary contraceptive supplies. However, this may prove to be an unrealistic expectation in some countries because of the scarcity of resources and competing programmatic demands.

Without a reliable supply of modern contraceptives, it will not be possible to make significant headway in providing RH/FP care. USAID should assist governments in improving both their contraceptive management capacity and plans for ensuring sustainable and self-reliant procurement operations. Such plans should also enable governments to ensure that contraceptive supplies are available to the most vulnerable population groups. In a limited number of countries currently facing severe resource constraints and serious contraceptive supply problems, it may be necessary for USAID to provide additional commodity funding to ensure minimal contraceptive security in the near term.

Recommendation
Expand support for social marketing efforts combining behavioral change and commodity distribution approaches.

To promote increased contraceptive security, USAID should provide additional resources for social marketing programs in E&E countries with serious commodity shortages. In countries with small potential commercial markets (e.g., nations in the Caucasus), regional approaches in which similar product lines are introduced across several countries should be considered.

Social marketing efforts that emphasize behavior change in conjunction with the distribution of contraceptives (including low-cost, high-quality condoms) to vulnerable populations should also be promoted. Such efforts are currently underway as pilot projects to combat HIV/AIDS in some E&E countries (e.g., PSI's work in the Central Asian Republics region). These programs, while successful in distributing condoms to such target populations as prostitutes, drug users, and sexually active students in pilot sites, are currently too small to have much national impact on reproductive behavior. In addition, these programs should give greater emphasis to supplying contraceptives to poor clients that cannot afford to purchase condoms at prevailing market prices.

RELIABLE DEMOGRAPHIC AND HEALTH INFORMATION IS ESSENTIAL FOR RH/FP PROGRAM DESIGN AND EVALUATION

Before USAID's involvement, many countries in the E&E region did not have reliable or comprehensive information on reproductive health and family planning. New DHS and RH information has greatly strengthened the quality of information concerning RH/FP conditions in the region, particularly with respect to the level of abortion and contraceptive prevalence. While population-based surveys have contributed to improved program designs and strategies, clinic-based service statistics are still not used

sufficiently for purposes of program monitoring. There is also little RH/FP operations research being done in the E&E region, a factor that may frustrate efforts to assess the success of new RH/FP interventions and health sector reforms in the region.

Recommendation
Strengthen program monitoring and evaluation.

With increased USAID support for RH/FP activities in the E&E region, there will also be an increased need for strengthening program monitoring and evaluation. The population-based DHS and RHS surveys funded by USAID have provided essential information on reproductive health. Such surveys should be supported in the future, but given the cost of these operations, they should not be undertaken more than once every four or five years. Steps also need to be taken to ensure that an indigenous host country capacity to conduct RH/FP surveys and analyze results is developed in the region, so that the reliance on foreign technical assistance is reduced in future years.

When undertaking future population-based surveys, consideration should be given to including the facilities module of the DHS—along with the core demographic and health questionnaires—to obtain better information on the capacity of existing health facilities and profiles of coverage patterns for various services. Such basic information is often outdated or simply unavailable.

In addition to population-based surveys, the capacity for undertaking project area and facility-based evaluations should be strengthened. Service statistics routinely collected by service providers remain underused as a tool for monitoring program performance. All too often, service statistics are reported to higher administrative levels without being effectively used by the facility that collected the information. In addition, increased use of standard operations research tools, such as client satisfaction surveys, clinic exit interviews, and situation analysis studies, should be more widely employed. Obtaining better information about provider attitudes and practices would also be useful in improving effective client–provider interaction.

THE RISING COST OF RH/FP SERVICES MAY INCREASINGLY LIMIT CLIENT ACCESS AND USE

Many E&E countries have experienced major economic disruptions since the breakup of the Soviet Union in 1991. At the same time, the cost of health services has risen sharply as government subsidies have either been reduced or eliminated. Consequently, the affordability of RH/FP care is a growing problem in the region that will require creative solutions, especially in poorer communities with more vulnerable populations. In Armenia, some success has been achieved in serving poorer households by holding health fairs (often on Saturdays) that provide basic counseling and services at no cost. Community-based social insurance programs that have been piloted in some countries may also hold promise. However, the fundamental problem that needs to be addressed is that health systems throughout the region have a serious lack of resources, and clients will likely be expected to cover a greater share of their health costs.

A growing danger confronting the region is that health care may increasingly be rationed by the ability to pay for it. Deteriorating access to formal health systems will likely lead

to a growing informal market for health care, in which inexpensive, unregulated services are provided offsite by both private and government doctors (working nights and weekends to supplement their incomes). This process is already gathering force in some E&E countries and poses a growing challenge to providing universal access to high quality RH/FP care.

Recommendation
Increased attention needs to be paid to the cost of RH/FP care and the ability of clients to pay for care.

Little information is available in the E&E region on patterns of household expenditures for health care and the extent to which services are currently affordable. In order to ensure greater access and use, it will be necessary to develop more precise regional and national profiles on the changing cost of RH/FP services to clients and the extent to which health systems can expect to recover costs from client payments. This information is essential in computing affordable prices for RH/FP commodities and services and in designing future subsidization strategies.

HIGH–QUALITY RH/FP CARE IS DEPENDENT ON INVESTMENTS IN HUMAN RESOURCE CAPACITY AND QUALITY MANAGEMENT SYSTEMS

Health system staffing patterns throughout the region are still poorly configured for providing good quality RH/FP care. There tends to be an oversupply of highly specialized obstetricians/gynecologists and not enough family doctors trained in RH/FP. In addition, nurses and midwives receive little instruction in basic RH/FP care and often have poor counseling skills. To make health systems more responsive to the RH/FP needs of clients, improved workforce management systems need to be introduced. This will entail training additional family doctors, nurses, and midwives in basic RH/FP skills and reducing the current dependence on obstetricians/gynecologists as the only frontline caregivers and counselors. Introducing new preservice training curricula in RH/FP for family doctors and other health workers needs to be an important future priority. To date, much of the instruction provided to family doctors and obstetricians/gynecologists has been oriented toward inservice rather than preservice training. In planning future service delivery strategies, job descriptions will need to be recast and efforts made to clarify to whom payments are made for particular services or procedures. Increased attention will also need to be given to policies affecting the remuneration, promotion, and retention of health providers in national health programs.

Recommendation
Strengthen quality management systems and workforce planning for RH/FP programs.

Additional steps will need to be taken to enhance the capacity of health systems to provide high quality and sustainable RH/FP care. Health systems in the region are still typified by highly specialized vertical programs emphasizing curative services rather than integrated reproductive and primary health care that emphasize education and prevention (e.g., of unintended pregnancies and reproductive tract infections). In many E&E countries, there are still too many providers being equipped with inappropriate skills and health facilities that are underused.

In particular, USAID will need to give greater attention to strengthening quality management systems and encouraging workforce planning for RH/FP care. For example, job descriptions and payment systems for RH/FP service providers still need to be clarified (e.g., between family doctors and obstetricians/gynecologists). In addition, equipping nurses and midwives, particularly those working in remote rural health posts and ambulatory centers, with new competencies in RH/FP counseling and service delivery, will be an important task for the future. These frontline health workers have not received the attention they deserve over the past decade. Managerial reforms that more clearly demarcate lines of authority between supervisors and providers will require additional attention, including the clarification of job descriptions for health personnel (especially family doctors, obstetricians/gynecologists, and nurses/midwives). Strengthening decentralized health system planning and budgeting is another growing managerial need in many E&E countries.

Increased attention also will need to be given to the financial sustainability of the region's RH/FP care. Steps will need to be taken to ensure access to care among poorer, more vulnerable populations. Pilot efforts in some countries for providing social insurance and drug benefits for infants and children will need to be studied carefully (and replicated when successful) to ensure broader access to RH/FP health care.

Recommendation
Give increased emphasis to preservice training and curriculum reform in supporting family doctor and family group practice services.

In supporting health sector reform initiatives, such as the introduction of new RH/FP standards/protocols and the training of family doctors, emphasis has been given to inservice training. Surprisingly little attention has been given to preservice training. The introduction of new RH/FP training curricula in medical schools responsible for graduating new service providers is an important priority in many settings. It will also be important to encourage additional evidence-based approaches to inservice training for obstetricians/gynecologists, family doctors, and nurses/midwives that emphasize clinical practice rather than theoretical instruction. Such initiatives will help ensure that the health sector reforms introduced in many E&E countries will become permanent features of the region's newly restructured health delivery systems.

APPENDICES

APPENDIX A

SCOPE OF WORK
(from USAID)

SCOPE OF WORK
FAMILY PLANNING/REPRODUCTIVE HEALTH IN E& E
ASSESSMENT

BACKGROUND

Concerns about the adverse impact on women's health in the E&E region from excessive use of abortion led to USAID's decision in the mid-1990's to begin to support programs promoting modern methods of contraception and providing information about the efficacy and safety of modern methods of contraception. The latest figures show that, during the five-year period from FY 1998 through FY 2001, USAID expended slightly more than $70 million on FP/ RH programs in 15 countries in the Europe and Eurasia (E&E) region. More than half of these estimated expenditures were spent in four countries: Armenia, Romania, Russia and the Ukraine. Annual estimated per capita expenditures for family planning/reproductive health activities ranged from roughly $15 in Russia to $500 in Armenia. Estimated annual per capita RH/FP assistance in two additional countries: Georgia and Kazakhstan was over $50. Support for RH/FP programs has continued steadily, partially in response to congressional earmarks and directives AEEB (Assistance to Eastern Europe and the Baltics) and FSA (Freedom Support Act) funds have helped meet the Agency's overall earmark for family planning. In 2004, Congress made available an additional $17 million in Child Survival Health funds to promote family planning to reduce abortions in six E &E countries: Albania, Azerbaijan, Georgia, Kazakhstan, Romania and Russia.

For several decades, abortion has been the primary means of birth prevention in most of the former Soviet bloc countries. Abortion rates in many of the E&E countries have been among the highest in the world. In a number of countries, the total abortion rate exceeds the total fertility rate. Although abortion without restrictions is generally available and legal during the first 12-14 weeks of gestation, some women seek abortions outside the legal system. The number of abortions recorded through population-based surveys is considerably higher in many countries then those registered. Unsafe abortion is one of the leading causes of maternal mortality and morbidity and secondary infertility. It is estimated that between 15 percent and 54 percent of maternal deaths in the region are abortion-related, presumably most of them from illegally performed abortions. This contrasts with the U.S. where about 4 percent of maternal deaths are abortion-related. Additionally, when asked in reproductive health surveys, 50-90 percent of women feel that abortion presents a high level of risk to their health.

USAID programs have promoted modern contraceptives as an alternative to abortion by strengthening the systems by which modern contraceptives are provided, training health care professionals in family planning, establishing contraceptive logistics management and information systems, providing information and education to target audiences, and conducting mass media campaigns. USAID, along with host country governments, other donors and private groups, has also supported a wide variety of RH/FP assistance programs and projects. These include:

- the addition or improvement of family planning services in government maternal or reproductive health systems;

- the training of health care professionals in family planning and reproductive health;
- the creation of special women's care or wellness centers, often through partnerships with U.S. institutions;
- the addition of cancer screening programs and pre- and post-natal care to RH/FP programs
- the integration of family planning information, referral and/or services in primary health care facilities;
- the provision of family planning information or services in family group health care practices; and
- the provision of family planning information and/or services through special family planning initiatives such as social marketing, media campaigns, etc.

While family planning use has increased in almost all the countries, many challenges remain such as major shortages of contraceptive supplies; lack of good information on modern methods; a lingering mindset against hormonal methods of contraception: an over reliance on single modern method, IUDs; and unacceptably high abortion rates in some countries. Of particular concern are the abortion rates in Georgia of 3.7 per woman and in Azerbaijan of 3.2 per woman; low use of modern methods of contraception (e.g. Albania's rate of 8 percent); inadequate training of general practitioners and family doctors in family planning and systemic issues which encourage health providers to promote abortion rather than contraception and women to choose abortion as the most affordable or feasible alternative to unplanned pregnancy.

During the past decade, USAID supported a number of major Demographic and Health Surveys (DHS) and Reproductive Health Surveys (RHS) to collect information on women's (and in some cases men's) health attitudes and behaviors. Between 1993 and 2002, 18 surveys were conducted in 13 countries in Eastern Europe and Eurasia. Romania, has had three national surveys. Two studies have been conducted in Kazakhstan, Russia (selected urban areas only) and Uzbekistan each.

These surveys, along with a recent comparative study looking at patterns of family planning use and abortion and related information on regional and country FP/ RH funding and program assistance patterns, provide a rich basis for an assessment of experience, lessons learned, best practices and the relative results associated with different patterns of investment in assistance over the past decade. The survey data document in most countries a strong relationship between the increased use of modern methods of contraception and the decreased use of abortion.

III. PURPOSE OF THE ASSIGNMENT

The purpose of this assignment is to assess how and whether USAID's assistance in family planning (FP) and reproductive health (RH) has contributed to improved delivery and increased use of modern methods of contraception and other reproductive health services; determine whether particular models of family planning provision appear to be more effective and efficient in contributing to changes in family planning service availability and use; capture lessons learned and best practices in FP and RH; identify constraints to program success; and identify opportunities for future programmatic directions for support of RH/FP..

The assessment will have three primary objectives:

- Provide an overview of the magnitude, nature and pattern of USAID assistance in reproductive health and family planning in the Europe and Eurasia (E&E) region over the past decade;
- Capture lessons learned and assess "best practices" in a sample of countries and assess the extent to which overall USAID assistance (and particularly assistance through specific modes or models) can be plausibly associated with changes in the availability and nature of RH/FP services and use of modern methods of contraception and reduction of abortion;
- Identify opportunities for future directions in support of family planning and reproductive health and ways to improve the impact of assistance on family planning use and reduction of abortion.

V. METHODOLOGY AND RESOURCES

A) Approach

The assessment will be conducted in two phases: Phase One will consist of a preliminary Washington "desk study" and Phase Two will consist of assessments done in a number of select countries and the compilation of a final analysis and report.

During the first phase, a consultant identified by POPTECH will, in conjunction with the E&E Health and Population Officer in the Bureau for Global Health, carry out a preliminary desk study to develop an overview of regional and country investments in FP and RH; conduct a review of RH/FP program activities in the region including the various project and contractual modalities employed; and compile to the extent feasible reported results including changes in family planning/ reproductive health behavior and service provision. Background materials for the desk study will include, but not be limited to, relevant academic and project literature including country and regional studies and evaluations, mission annual reports, contractor and grantee reports, special surveys and other related materials. It may include informational interviews with key informants in the Washington area and others involved with USAID projects.

During this phase, the consultant will develop and disseminate a self-assessment tool to missions and partner organizations (including cooperative agencies and contractors which have worked in the E&E countries) and analyze the results of this self-assessment. The results of the desk review and assessment will be summarized in a report not to exceed 10 pages.

In on-going consultation with the Health and Population Officer for E&E in the Bureau for Global Health and other members of the E&E health team and the Bureau for Global Health when appropriate, the consultant will develop background materials and recommendations for the phase 2 field reviews in 2-4 countries. Among the criteria that will be used in selecting sites for the Phase Two field work will be:

- the nature and magnitude of USAID investment in family planning/reproductive health in the country;
- the opportunity to examine the results, lessons learned and experience with different models of family planning assistance;

- the opportunity to review family planning assistance in a least two if not three of the major geographic regions in E&E where USAID provides family planning/reproductive assistance, i.e. Eastern Europe, the Caucuses and other parts of Eurasia;
- the availability of survey and other data and results in increasing access to RH/FP, increases in service delivery, and changes in policy and behavior where possible to assess regarding the use of modern methods of contraception and abortion practice;
- the willingness of USAID field staff to sponsor and possibly assist in the assessment, and
- if feasible, the opportunity to look at countries where USAID assistance may have contributed to major changes in family planning use and abortion and where such change appears not to have occurred despite USAID assistance.

In conjunction with the Health and Population Officer for E&E in the Bureau for Global Health, the Phase Two consultants will develop the protocols for field reviews in 2-4 activities will include recruiting and supporting the assessment team (including travel, per diem and related team expenses), compiling Mission responses, providing logistical support including setting up meetings in Washington and the countries visited, translation and secretarial support and distributing draft and final reports. For budget planning and estimation purposes, please estimate travel costs on the basis of two week visits to Armenia, Kazakhstan and Romania. It is envisioned that both consultants would complete the first field visit together and then divide to the complete the next two visits.

With the assistance of the E&E senior family planning advisor the consultants will develop the protocols for field reviews in 2-4 countries which draw upon the earlier analysis. The field studies will seek to

- confirm the nature and magnitude of U.S. assistance and its relevance to family planning/reproductive health,
- review reported program and project outputs and outcomes,
- determine if materials, protocols, systems and services developed under USAID assistance are being used, replicated and/or expanded with other support to improve service delivery quality more broadly or to reach other populations or areas.
- look for best practices and lessons learned,
- seek to determine the extent to which USAID and related partner assistance can be plausibly associated with changes in provider and client family planning attitudes toward and knowledge of modern methods of contraception; the quality, availability and coverage of family planning services, and changes related to contraceptive practice and abortion.

In order to look at the "big picture, wherever possible, the consultant(s) should focus on national or at least regional changes rather than project site findings. In those cases where the assistance has ended, the consultant(s) should seek to determine whether improved service delivery systems are being continued, services are still being provided and contraceptives are available. Overall "lessons learned" and "best practices" should be emphasized.

In carrying out the country field reviews, the consultant(s) will need to follow a common protocol for the assessments in each country and, to the extent feasible, use common instruments for interviews with providers, clients and other stakeholders and other data collection, analysis and reporting. It is expected that a combination of structured and unstructured interviews will be used.

DATA SOURCES

The Health and Population Officer for E&E in the Bureau for Global Health will work with the consultant team to make background materials available and work with USAID field missions to identify key contacts and facilitate responses from the field when appropriate.

Background materials might include, but not be limited to:

- *Reproductive, Maternal and Child Health in Eastern Europe and Eurasia: A Comparative Report*. This report summarizes the major findings from 16 RHS and DHS surveys done in 12 countries in E&E since 1996 and was prepared by CDC and MACRO International with support from USAID's E&E Bureau.

- Reproductive Health Trends in Eastern Europe and Eurasia" prepared by the Population Reference Bureau and summarizing the above report.

- Professor Charles Westoff's analyses of survey data and country service statistics to examine trends focusing on increases in modern methods of contraception and consequent reductions in abortion in several E&E countries.

- Population Reports, "The Reproductive Revolution Continues".

- IBRD's *Health in Europe and Central Asia* which provides a good overview of health issues in the region.

- USAID's FY2001 and FY2002 Agency-wide Expenditures for Family Planning, HIV/AIDS, Health and Nutrition which provide reproductive health and family planning expenditure data for E&E from the late 1990's through 2002.

- Congressional Budget Justifications for E&E countries.

- E&E mission annual reports and mission websites.

- Reports, including final project reports from CAs and Contractors who have worked in the E&E region.

FOCUS OF THE ASSESSMENT

In both Phase One and Phase Two, the consultants should be sure that the following five questions are addressed. Additional illustrative questions that may be considered by the consultants can be found in the appendix at the end of this Scope of Work.

1. To what extent can it be determined that USAID-assisted RH/FP programs can be plausibly associated with changes in policy and service delivery?

2. What are the different ways in which RH/FP services (for example, integration of RH/FP into primary health care) and communication campaigns been designed and implemented in the E&E region? What are the "lessons learned" from the different approaches, and what "best practices" can be emulated and repeated in subsequent USAID assistance plans or implementation? What opportunities exist for future programming?

3. Have there been opportunities to connect RH/FP with related areas such as health reform, child survival, HIV/AIDS, trafficking and local government? If so, what have been the "lessons learned" and "best practices" from the linkages?

4. How have USAID RH/FP earmarks and directives and guidelines influenced or determined the design and implementation of RH/FP assistance programs?

5. What have other donors done in the E&E region in RH/FP and how likely is their support to continue? What has been USAID's comparative advantage in supporting RH/FP? What crossover exists with USAID programs and those of other donors, and how have "lessons learned" and "best practices" been shared to everyone's advantage?

PROPOSED LEVEL OF EFFORT

It is estimated that 4-6 weeks of full and part-time consultant's time will be required for Phase One which will preferably be done in Washington. It is estimated that 2.5-3 month's time will be required for one field consultant. In addition, 3 months' time will be required for a team leader for the field reviews and final analysis. An additional two weeks may be needed for the team leader to complete writing and/or participate in Phase One. Phase 1 of the assessment should begin in late May or early June and the assignment including debriefings and final reports should be completed by late September. A full timeline will be developed by the Health and Population Officer for E&E in the Bureau for Global Health in conjunction with POPTECH.

DELIVERABLES

A. Debriefings

The assessment team, or at least the team leader will conduct separate, sequential debriefings for the USAID/E&E Health Team and for a larger E&E Bureau and agency audience. This will include the preparation and delivery of a power point presentation which summarizes the team's principal findings.

B. Reports

Two reports will be submitted. The first report which will be no longer than 10 pages will summarize the Phase 1 findings and recommendations for country site visits. The second report which will be shared with USAID in both draft and final format will follow

standard report preparation guidelines, contain clear findings, conclusions and recommendations and address the study objectives and questions. This report will be no longer than 40 pages excluding annexes and be submitted in hard copy and electronic format. The report will include a table of contents, executive summary of no more than three pages, background and methodology sections, program description and summary of findings, conclusions and recommendations. The latter should be organized and presented in a brief succinct actionable format. The Annexes will include but not be limited to responses to the self assessment, country summaries, references, lists of persons contacted, etc.

VIII. TEAM COMPOSITION

The assessment team will consist of three consultants who ideally will have the following qualifications:

1. A team leader with extensive experience in RH/FP program management and implementation, preferably with USAID, and who possesses excellent evaluation, interpersonal, writing and facilitation skills.

2, A senior RH/FP technical expert with extensive experience in the design and implementation of family planning policy and service delivery programs.

3. A social science analyst familiar with family planning program design, questionnaire development and the collection and analysis of technical and program data to carry out the phase 1 review and prepare and compile the results of the self-assessment instrument .

IX. FUNDING, SCHEDULING AND LOGISTICS

All funding and logistical support will be provided through POPTECH. POPTECH activities will include recruiting and supporting the assessment team (including travel, per diem and related team expenses), compiling Mission responses, providing logistical support including setting up meetings in Washington and the countries visited, translation and secretarial support and distributing draft and final reports. For budget planning and estimation purposes, travel should be calculated to include the costs for two consultants to visit Romania, Georgia or Armenia and Kazakhstan for two weeks each.

ILLUSTRATIVE QUESTIONS THAT MIGHT BE ADDDRESSED IN THE DESK STUDY AND/OR DURING THE FIELD VISITS

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A) Overview of USAID Assistance in Reproductive Health and Family in E &E

1. How much assistance in FP/ RH has USAID provided on a regional and country basis over the past decade?

2. Which countries have received the greatest amount of assistance in the past decade (or, if this can not be determined, in the last five years), on a total and per capita basis?

3. What has been the relative investment in different models of FP/ RH assistance? Are there particular contractors or grantees associated with these approaches and activities?

4. Is there a pattern to assistance related to specific countries or sub regions of E&E?

5. What information is readily available through mission or contractor/grantee reports on the results of this assistance at the regional or country level? What are the major products or results reported? To what extent is there national or regional reporting on changes in provider or client knowledge and attitudes, the nature, quality and coverage of family planning services, client behavior and family planning and abortion practice, etc.? How do these differ among missions, contractors/grantees and other partners?

7. Do the nature and magnitude of results including service coverage appear to vary substantially by models or types of assistance provided? Do certain models appear to be more effective or efficient in expanding family planning service delivery, population coverage and/or adoption of modern methods of contraception?

8. Does the desk study suggest particular countries where USAID assistance appears to be associated with significantly more or less change in family planning behavior and abortion practice?

B) Results, Accomplishments & Lessons Learned in a Sample of USAID-Assisted Countries

1. What are the principal constraints to modern method family planning use to which USAID assistance has been directed? How successful has USAID been to overcoming these constraints? Are there other constraints which USAID assistance needs to address? Are there other changes that need to be made in USAID assistance to increase its impact on modern method contraceptive use?

2. What have been the major products and program successes and failures?

3. Are there clear differences in family planning service delivery and practice between those areas in which USAID has worked and those where it hasn't.?

4. To what extent can USAID-assisted RH/FP programs be plausibly associated with changes in policy, service delivery and/or behavior or other products or outcomes?

5. Have successful models of RH/FP training, information dissemination and service delivery been replicated and expanded with non-USAID resources? How extensive has this been?

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6. In those cases, where USAID assistance has ended, are the products of that assistance, e.g. RH/FP protocols, information dissemination and service programs being continued with local or other resources? One example might be the sustainability of family planning service delivery and use at Women's Wellness Centers and other partnership programs? For current, on-going activities, what are the prospects for sustainability?

7. How have USAID RH/FP earmarks/directives and guidelines influenced or determined the design and implementation of RH/FP assistance programs?

8. Where appropriate, to what extent has RH/FP services been successfully integrated into PHC? Where has this worked and what have been some of the contributing factors?

9. .What are some of the primary factors contributing to improved RH/FP coverage, quality and adoption? Are there messages regarding overall maternal health or infant mortality that could be used to make programs more effective?).

C) Recommendations for Future USAID Investments in Reproductive Health and Family Planning

1. What do the findings of this suggest in terms of the levels and types of USAID RH/FP assistance include support for special studies or surveys, which will be the most effective and efficient in increasing the successful use of modern methods of family planning (and decreasing use of abortion as a means of family planning)?

2. How do these vary by region and country?

3. Is there a minimum floor (or length) of assistance which USAID and its partners must achieve for the assistance to have any value?

4. Are there certain pre-conditions or commitments by host country governments, non-governmental groups or other donors that must be place before USAID assistance should be provided?

5. Are there best practices in RH/FP assistance which should be emulated and repeated in subsequent assistance plans or implementation?

6. What are the some of the lessons learned that need to be shared with those designing and managing USAID RH/FP assistance?

7. Are there opportunities to connect RH/FP programs with related areas such as health reform, child survival, HIV/AIDS, trafficking and local government? If so, what are some of the benefits and costs associated with such broader programming?

APPENDIX B

PERSONS CONTACTED

PERSONS CONTACTED

USAID/WASHINGTON

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Mary Jo Lazear, Europe and Eurasia Health and Population Officer, Bureau for Global Health

ARMENIA

USAID/Armenia/Democracy and Social Reform Office
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Nicholas Bruno, Health Adviser
Anna Grigoryan, Project Management Specialist

Ministry of Health
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Zemfira Margaryan, Director, Vanadzor Polyclinic 5
Karine Yanashyan, Pediatrician, PRIME II Clinical Trainer, Vanadzor Polyclinic 5
Sonya Arushanyan, Pediatrician, Director, PRIME II Clinical Trainer, Vanadzor Polyclinic 4
Aram Avalyan, Director, Maternity Department, Chief Obstetrician/Gynecologist of Marz, Vanadzor Hospital Complex 1, Maternity Department (PRIME II Clinical Training Site)
David Shahverdyan, Obstetrician/Gynecologist, Deputy Director, Maternity Department, Clinical Trainer, Vanadzor Hospital Complex 1, Maternity Department (PRIME II Clinical Training Site)
Armine Gharadjyn, Family Doctor, Director (Family Medicine Clinical Trainer, Vardablur Ambulator Center (or Family Medicine Center)
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American International Health Alliance
Ruzan Avetisyan, Program Coordinator

Armenia Family and Health Association
Mary Khachikyan, Executive Director

Armenia Social Transition Program (ATSP) Health Sector Reform Project
Ruben Jamalyan, Primary Medical Care Delivery and Training Specialist
Tatyana Makarova, Health Team Leader, Senior Health Policy Adviser

PRIME II Project
Rebecca Kohler, Country Director
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Iren Sargsyan, Gender-Based Program Coordinator
Karine Bagdasarova, Lori Marz Coordinator
Zara Melkonyan, Supportive Supervisory Project

Lilit Hevekimyan, Clinical Adviser
Lusine Ghazoryan, Sexually Transmitted Infection (STI) Project
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United Nations Population Fund (UNFPA)
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KAZAKHSTAN

USAID/Kazakhstan
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Mary Skarie, Public Health Management Specialist
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Schering AG
Tushakova Alfya, Sales Development Manager
Mira Sauranbaeva, Former Red Apple Hotline Supervisor

Business Women's Association
Raushan Sarsembayera, Director

Interfarma-K
Audrius Jozenas, General Director
Amiznechanova Karlypash, Deputy Head of Procurement

ZdravPlus
Asta Maria Kenney, Regional Deputy Director for Programs
Malika Baiserke, Public Health Programs Coordinator
Nadezhda Khe, Consultant
Olga Gubanova, Karagnda Oblast Coordinator

Population Services International (PSI)
Chris Jones, Regional Director

Republican Center of Health Protection of Mother and Child
Nagima Mamedalieva, Director of Science

American International Health Alliance (AIHA)
Zhamilya Nugmanova, Regional Director for Central Asia
Bauyrzhan Amirov, Senior Program Coordinator

UNFPA
Aida Alzhanova, Assistant Representative
Konstantin Osipov, National Programme Officer

Women's Wellness Center, Almaty
Eleonora Hakaraliyevna, Deputy Director

U.S.–Kazakhstan Health Center
Asel Dzhaimbetova, Manager

Karaganda Oblast Health Department
Kanat Yermekbayev, Oblast Health Director
Gul Turubenovna Omarova, Chief Gynecologist

Karaganda Family Physicians Association
Ludmila Makhazhanova, Director

Nur Family Outpatient Clinic, Karaganda
Maral Bayazitova, Chief Physician
Irina Nemilosteva, Obstetrician/Gynecologist

ROMANIA

USAID/Romania
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Cate Johnson, Director, Democracy and Social Sector Reform Office
Gabriela Paleru, Democracy and Social Sector Reform Office
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Mark Lopes, Desk Officer for Romania

JSI Research and Training Institute, Inc., Romanian Family Health Initiative
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Alin Stanescu, Director
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Romanian Association Against AIDS (ARAS)
Galina Musat, Project Coordinator

GRASP Project
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Society for Education on Contraception and Sexuality (SECS)
Borbala Koo, Executive Director
Adriana Melnic, Regional Coordinator, Cluj District

Youth for Youth Foundation (YfY)
Alexandru Negut, Program Director

East European Institute for Reproductive Health (EEIRH)
Mihai Horga, President, Former Director of Mother and Child Health, MOH

Romanian Cancer Society
Marlene Farcas, Director

Public Health and Health Management Department, Cluj District
Cristina-Maria Borzan, Director
Dorina Duma, Mother and Child Health Program Inspector

Community Center, Mociu, Cluj District
Angela Constantinescu, Family Doctor

UNFPA/Romania
Stela Serghiuta, Programme Officer
Camelia Ieremia, Administrative/Personnel Associate

APPENDIX C

STATISTICAL TABLES AND CHARTS

STATISTICAL TABLES AND CHARTS

Table C–1
Demographic Indicators for Countries in the European and Eurasian (E&E) Region with USAID–Supported RH/FP Activities
(Most Recent Estimates)

	Population (Millions) 2001	GNP Per Capita (US$)	Population Growth Rate	Total Fertility Rate	Infant Mortality Rate	Life Expectancy	
						M	F
Eastern Europe							
Albania	3.1	3,506	-0.32	2.6	28.3	69.9	75.9
Moldova	4.2	2,109	-0.20	1.8	20.5	62.8	70.3
Romania	22.3	6,423	-0.22	1.3	31.5	66.5	73.3
Russia	143.6	8,378	-0.36	1.3	16.7	60.2	72.5
Turkey	68.5	6,974	1.62	2.2	28.7	66.5	71.7
Ukraine	48.5	3,816	-0.78	1.4	15.3	62.7	73.5
Caucasus							
Armenia	3.7	2,559	0.14	1.7	36.1	69.3	75.4
Azerbaijan	8.1	2,936	0.91	2.1	74.4	67.2	74.5
Georgia	5.2	2,664	-0.34	1.7	41.6	68.5	76.8
Central Asia							
Kazakhstan	16.0	5,871	-0.53	2.1	61.9	58.6	69.9
Kyrgyzstan	5.0	2,771	1.51	3.4	61.3	62.8	71.1
Tajikistan	6.0	1,152	1.17	3.7	56.6	64.2	70.2
Turkmenistan	4.9	3,956	2.36	2.9	73.9	61.9	68.9
Uzbekistan	25.5	2,441	1.76	3.4	49.1	65.3	71.3

Sources: United Nations Population Fund, www.unfpa.org/profile, 2004; U.S. Department of Health and Human Services, 2003:22, 168; Turkey Demographic and Health Survey, 2003

Table C–2
RH/FP Indicators for Countries in the Europe and Eurasia Region
(Most Recent Estimates)

	Contraceptive Prevalence All Methods	Contraceptive Prevalence Modern Methods	Unmet Need for FP	Maternal Mortality Ratio	Percentage of Deliveries With Skilled Attendant	HIV/AIDS Prevalence (15–24)
Eastern Europe						
Albania	75	8	43	31	99.1	-
Moldova	74	50	6	65	99.1	.298
Romania	64	30	-	60	97.9	1.928
Russia	73	53	12	75	-	1.268
Turkey	71	43	6	55	83.0	.000
Ukraine	68	38	18	45	99.0	1.415
Caucasus						
Armenia	61	22	15	29	96.9	.143
Azerbaijan	55	12	12	37	87.5	.038
Georgia	41	20	24	22	96.4	.048
Central Asia						
Kazakhstan	62	55	15	80	99.1	.080
Kyrgyzstan	60	50	13	80	97.9	.000
Tajikistan	34	27	-	120	76.8	.000
Turkmenistan	55	47	19	53	97.2	.000
Uzbekistan	57	53	14	60	96.0	.005

Sources: United Nations Population Fund, www.unfpa.org/profile, 2004; U.S. Department of Health and Human Services, 2003:62, 79; Turkey Demographic and Health Survey, 2003

Table C–3
Percentage of Currently Married Women Aged 15–44 Currently Using Contraception by Method

Region and Country	All Methods	Modern Methods	Oral Contraceptives	IUDs	Condoms	Tubal Ligation	Other Modern	Traditional
Eastern Europe								
Albania 2002	75	8	1	1	2	4	0	67
Moldova 1997	74	50	2	38	6	3	0	24
Romania 1999	64	30	8	7	9	3	3	34
Russia 1999*	73	53	7	25	16	2	3	20
Turkey 2003	71	43	5	20	11	6	1	29
Ukraine 1999	68	38	3	19	14	1	1	30
Caucasus								
Armenia 2000	61	22	1	10	8	2	0	39
Azerbaijan 2001	55	12	1	6	3	1	0	44
Georgia 1999	41	20	1	10	6	2	1	21
Central Asia								
Kazakhstan 1999	62	55	3	44	5	3	1	8
Kyrgyzstan 1997	60	50	2	39	6	2	1	9
Turkmenistan 2000	55	47	1	41	3	2	1	8
Uzbekistan 1996	57	53	2	47	2	1	2	4

* Russia data based only on three urban oblasts

Sources: U.S. Department of Health and Human Services, 2003:62; Turkey Demographic and Health Survey, 2003

Table C–4
Percentage of Currently Married Women Obtaining Contraceptive Methods from Public, Private, Commercial, and Other Sources

Region and Country	Public	Private	Commercial	Other
Eastern Europe				
Albania 2002	66	1	30	3
Moldova 1997	72	0	24	4
Romania 1999	32	8	51	8
Russia 1999*	38	0	59	3
Turkey 2003	58	2	40	-
Ukraine 1999	55	0	34	11
Caucasus				
Armenia 2000	65	1	24	10
Azerbaijan 2001	54	2	35	9
Georgia 1999	54	1	37	7
Central Asia				
Kazakhstan 1999	76	2	20	3
Kyrgyzstan 1997	83	0	14	2
Turkmenistan 2000	95	1	4	0
Uzbekistan 1996	92	0	6	1

* Russia data based only on three urban oblasts

Sources: U.S. Department of Health and Human Services, 2003:62; Turkey Demographic and Health Survey, 2003

Table C–5
Inconsistencies in Reporting of Abortions Between Demographic and Health Surveys and Official Government Statistics
(General abortion rate per 1,000 women)

Region and Country	Period	Survey	Official
Eastern Europe			
Albania	1999–2001	73	200
Moldova	1994–1996	43	43
Romania	1997–1999	74	62
Russia*	1996–1998	80	-
Turkey	-	-	-
Ukraine	1997–1999	55	42
Caucasus			
Armenia	1998–2000	81	17
Azerbaijan	1998–2000	116	10
Georgia	1997–1999	125	18
Central Asia			
Kazakhstan	1997–1999	47	32
Kyrgyzstan	1995–1997	45	31
Turkmenistan	1998–2000	26	-
Uzbekistan	1994–1996	20	16

* Russia data based only on three urban oblasts

Source: U.S. Department of Health and Human Services, 2003:38

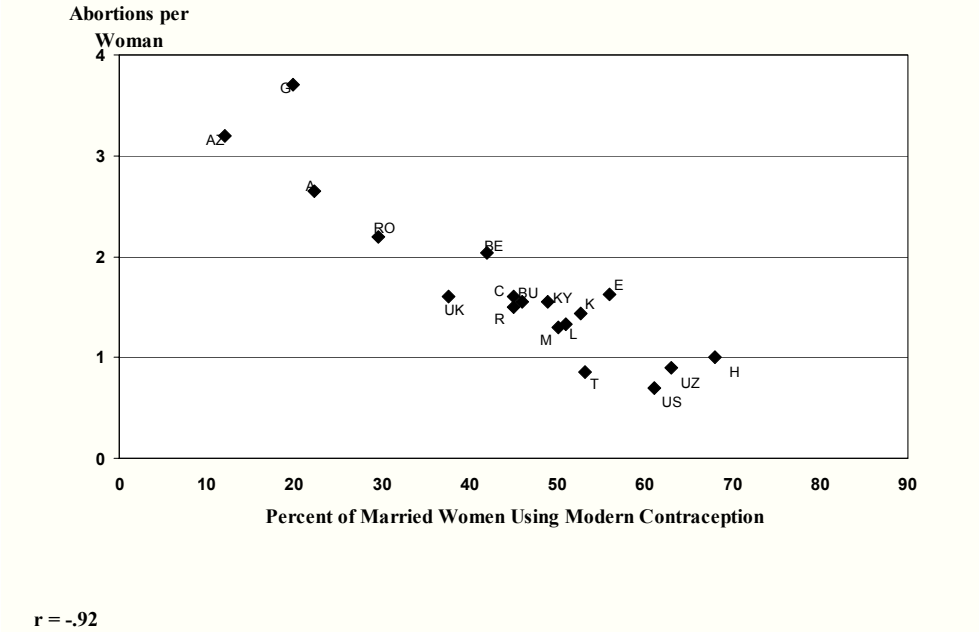
Table C–6
Percentage of Unintended Pregnancies, Percentage of Unintended Pregnancies Aborted, and Percentage of Abortions With Reported Complications

Region and Country	Percentage of Unintended Pregnancies	Percentage of Unintended Pregnancies Aborted	Percentage of Abortions With Reported Complications
Eastern Europe			
Moldova 1997	42	83	11.2
Romania 1999	55	82	7.7
Russia 1999*	66	83	13.7
Turkey 2003	34		
Ukraine 1999	54	82	14.1
Caucasus			
Armenia 2000	62	87	-
Azerbaijan 2001	57	84	16.3
Georgia 1999	59	90	7.5
Central Asia			
Kazakhstan 1999	-	-	-
Kyrgyzstan 1997	34	71	-
Turkmenistan 2000	-	-	-
Uzbekistan 1996	16	74	-

* Russia data based only on three urban oblasts

Sources: U.S. Department of Health and Human Services, 2003: 45; Turkey Demographic and Health Survey, 2003

Figure C–1
Total Abortion Rate and Prevalence of Modern Contraceptive Methods in 17 E&E Countries and the U.S.



r = -.92

Country Key

A	Armenia
AZ	Azerbaijan
BE	Belarus
BU	Bulgaria
C	Czechoslovakia
E	Estonia
G	Georgia
H	Hungary
K	Kazakhstan
KY	Kyrgyz Republic
L	Latvia
M	Moldova
RO	Romania
R	Russia
T	Turkmenistan
UK	Ukraine
US	United States
UZ	Uzbekistan

Source: Westoff 2004

Table C–7
Trends in Total Abortion Rates Among Women Aged 15–39
in Selected Countries in the E&E Region

Region and Country	Total Abortion Rate			Modern Contraceptive Prevalence
	6–8 Years Before Survey	1–2 Years Before Survey	Absolute Change	Percentage Change 5 Years Before Survey
Eastern Europe				
Moldova 1997	1.6	1.2	-0.4	13
Romania 1999	3.2	2.0	-1.2	14
Russia 1999*	2.6	2.2	-0.4	15
Turkey 2003	-	-	-	-
Ukraine 1999	1.6	1.5	0.0	14
Caucasus				
Armenia 2000	3.1	2.5	-0.6	-
Azerbaijan 2001	2.3	2.9	0.6	40
Georgia 1999	4.3	3.4	-0.9	20
Central Asia				
Kazakhstan 1999	1.6	1.3	-0.3	-
Kyrgyzstan 1997	1.2	1.4	0.2	-
Turkmenistan 2000	0.7	0.8	0.1	-
Uzbekistan 1996	0.9	0.6	-0.3	-

*Russia data based only on three urban oblasts

Source: U.S. Department of Health and Human Services, 2003:62, 68

Table C–8
Percentage of Mothers With No Antenatal Care During Pregnancy and the First Trimester and No Postnatal Care Up to 6 Months Following Delivery
(in percentages)

Region and Country	No Prenatal Care During Pregnancy	No Prenatal Care During First Trimester	No Postnatal Care 6 Months After Delivery
Eastern Europe			
Albania 2002	19	41	20
Moldova 1997	1	73	26
Romania 1999	11	60	68
Russia 1999*	4	83	-
Turkey 2003	24	42	-
Ukraine 1999	10	65	42
Caucasus			
Armenia 2000	8	54	-
Azerbaijan 2001	30	45	75
Georgia 1999	9	63	89
Central Asia			
Kazakhstan 1999	5	60	-
Kyrgyzstan 1997	3	72	-
Turkmenistan 2000	2	72	-
Uzbekistan 1996	5	73	-

*Russia data based only on three urban oblasts

Sources: U.S. Department of Health and Human Services, 2003:99, 100, 101; Turkey Demographic and Health Survey, 2003

Table C–9
Reproductive Services Obtained by Women of Reproductive Age in the E&E Region

Region and Country	Ever Had Pelvic Examination	Had Pelvic Examination in Last 12 Months	Ever Done Breast Self-Examination	Ever Had Cervical Cancer Screening	Ever Diagnosed With Pelvic Inflammatory Disease
Eastern Europe					
Moldova 1997	93	70	48	43	26
Romania 1999	70	36	39	17	31
Russia 1999*	91	65	-	-	17
Turkey 2003	-	-	-	-	-
Ukraine 1999	92	65	-	-	44
Caucasus					
Armenia 2000	71	21	9	-	-
Azerbaijan 2001	58	22	10	2	42
Georgia 1999	72	30	23	4	25

* Russia data based only on three urban oblasts

Source: U.S. Department of Health and Human Services, 2003:113, 114, 115, 117, 120

APPENDIX D

USAID SUPPORT FOR RH/FP PROGRAMS IN ARMENIA

USAID SUPPORT FOR RH/FP PROGRAMS IN ARMENIA

BACKGROUND

Armenia has faced many challenges in sustaining its financial support for social and health services since the collapse of the Soviet Union in 1991. The country has experienced significant declines in the accessibility of health care largely because of the rapid decrease in funding for health care from the national budget since the country's economic collapse in the early 1990s. This has resulted in dilapidated facilities, inoperable or missing equipment, an inability to restock supplies in a timely manner, and an increase in informal client payments for services. At the same time, the country has been struggling to improve the quality of care in a severely constrained resource environment.

USAID's Armenia Social Transition Program (ASTP) has been working to reduce the adverse impact of the economic transition from a command-driven to a market-based economy by strengthening the country's social and economic infrastructure and protecting the more vulnerable segments of the Armenian population. In the health sector, USAID focuses on establishing sustainable health delivery systems; improving the use of high-quality, primary health care services; and providing direct assistance to meet the nutritional needs of vulnerable groups.

FINDINGS

Over the past decade, USAID/Armenia has worked to improve public knowledge about basic RH/FP care and to strengthen the provision of high-quality, RH/FP care within the country's primary health care system. Several cooperating agencies have participated in this work, most notably the PRIME II Project, the Population Communication Services program of Johns Hopkins University (JHU/PCS), PADCO, Inc., and the American International Health Alliance (AIHA). Principal features of this assistance are described below.

Behavior Change and Communication (BCC)

The Reproductive Health Information Campaign, implemented by JHU/PCS (often referred to as the Green Path Program), provided information on RH/FP through Armenia's mass media and community organizations. The program also strengthened 77 family planning counseling and service centers (cabinets) in collaboration with the Armenian Ministry of Health (MOH) and UNFPA. As of 2004, 75 of these facilities were still providing information and services. While this program was successful in greatly increasing the use of RH/FP care, it also generated considerable public opposition. The project was viewed as an effort to impose small family norms and contraception on a population that already had low fertility and on a government with pronatalist leanings. JHU/PCS produced additional television messages that informed the public about the social and health benefits of the Green Path Program while emphasizing the right of families to choose the number of children they wish to have. The Green Path Program is often remembered for the public controversies that ensued following the Armenian government's attempts to portray RH/FP programs as little more than efforts to limit fertility, reduce family size, and impose small family norms in the country. However, in

spite of the Armenian government's pronatalist orientation, the project was ultimately successful in documenting the high demand for modern contraception in Armenia and contributing to substantial gains in contraceptive use within the family planning cabinets supported by the project.

Strengthening the Integration of RH/FP Care With Primary Health Care

In recent years, the PRIME II Project has been the major RH/FP initiative supported by USAID/Armenia. The project was initiated as a pilot effort in one region of the country (Lori Marz) encompassing 60 rural government health facilities. The main objectives of the project have been to improve the performance of rural health facilities and providers (e.g., by improving health service delivery policies and standards and providing clinical skills training and hands-on experience for nurses and midwives in rural health facilities); strengthen the RH/FP components of family medicine training; improve sexually transmitted infection (STI) syndromic management at primary health care facilities; and improve provider response in dealing with violence against women. The PRIME II Project has also made efforts to strengthen community outreach programs supplying preventive health measures and basic information on reproductive and primary health services.

Since 2001, the PRIME II Project has made important contributions to RH/FP health service delivery. Principal activities have focused on the following areas: provider skills training, policy and management, training capacity, and community mobilization.

Provider Skills Training

The project developed and implemented an MOH–certified, self-paced course in RH/FP clinical methods and developed MOH–approved training centers for family doctors and nurses in two hospitals and two polyclinics. These training activities are thought to have improved the quality of care in participating facilities, and have been associated with gains in antenatal visits, home visits, and referrals to second tier–level health facilities.

Policy and Management

New regulations on the safety and quality of maternal and infant care have been developed, updated national guidelines on integrating STI diagnosis and treatment in primary health care facilities have been introduced, and improved management procedures pertaining to job descriptions, the organization of clinical work, and the acquisition of clinical skills has also been promoted. Training in supportive RH/FP supervision procedures was also conducted in collaboration with Management Sciences for Health (MSH).

Training Capacity

RH/FP national training capacity in certified government institutions has been strengthened, curricula updated, and official clinical practice sites established; 13 national trainers currently provide instruction on STI treatment and prevention; and a clinical training program on RH/FP for family physicians has been developed by the Armenian National Institute of Health and State Medical University that currently involves 13 faculty members.

Community Mobilization

In collaboration with Save the Children, community action councils have been created in 20 communities to address local preventive and curative health needs. In addition, as part of the PRIME II–Save the Children partnership, 14 committees have piloted successful community mobilization efforts to enhance awareness and knowledge of local reproductive and child health needs. The project engaged community leaders, private citizens, and health providers in identifying local health conditions and priority service requirements. As part of this effort, local communities introduced drug procurement schemes (with seed money provided from village municipal budgets) for the purchase of pharmaceuticals at wholesale prices. This community pharmacy model is open to all residents, not just residents willing to pay membership fees or poorer households that otherwise could not afford essential medicines. This project has also raised resources for upgrading the physical infrastructure of existing health centers and informing local populations about these enhanced facilities.

The PRIME II Project has clearly made considerable progress in training family doctors, enhancing the provision of RH/FP care in their pilot sites. Family planning counseling and service provision has also risen substantially. Before the start of the project, no clients were receiving FP counseling at project health posts in Lori Marz. By the end of the project, an average of 5.5 clients per month were receiving FP counseling in project areas, compared with none in the control area of Shirak Marz (PRIME II Armenia 2004:7). Efforts to upgrade health posts and rural ambulatory facilities (which included the supply of basic equipment and supplies) appear to have been successful. Improvements in management and supervision practices have also achieved short-term results, but whether these management reforms can become permanently embedded in these pilot sites remains to be seen.

The Violence Against Women Program at Polyclinic 8 in Yerevan was organized to provide counseling and shelter to women who have been victims of sexual abuse and domestic violence. Before the initiation of this program, little attention was given to the needs of women victimized by violence. The Violence Against Women Program appears to have been a success given the surprisingly large number of women served, the enthusiastic response of service providers, and the relatively low cost of this service. This pilot project could be easily replicated at little cost. In addition, hotline services that provide basic information on RH/FP is an inexpensive way to promote greater use of services.

Efforts have also been made as part of the PRIME II Project to introduce evidence-based maternity protocols in the training curricula for obstetricians/gynecologists. This effort has also produced impressive short-term improvements in the quality of maternity care. In the maternity hospital in Lori Marz, PRIME II training has been instrumental in enhancing the ability to identify active and latent periods of labor (a distinction unknown in Soviet medicine). This newly acquired capability has led to reductions in the routine use of drugs during labor. In addition, infection procedures have been improved and the use of invasive and unnecessary surgical procedures curtailed. However, the Lori Marz Maternity Hospital still suffers from overcrowding (e.g., three beds to a room), old equipment, occasional shortages of essential supplies (such as bed sheets and gloves), and

unreliable stocks of contraceptives (e.g., the facility had no IUDs at the time of the field visit).

USAID has recently agreed to support a new RH/maternal and child health (MCH) program that extends the successes of the PRIME II Project to rural areas throughout the country. This activity, known as Project NOVA, will be implemented by the Emerging Markets Group, with IntraHealth International, Inc., as the key subcontractor and Save the Children as a secondary partner. Project NOVA is a five-year program that focuses on four key areas:

- improving rural RH/MCH primary health care provider knowledge and clinical skills and supplying basic primary health care medical equipment and supplies to support program activities through reinforcing national and marz-level training systems in RH/MCH, direct clinical training of primary care providers, and ensuring that primary care facilities have the necessary tools and supplies to offer quality services;

- developing the capacity of regional health officials and local health facility administrators and practitioners to improve the quality of rural RH/MCH service management and delivery, ensuring the sustainability of successful practices through introducing sound management and quality improvement practices at the primary health care level, and developing local capacity to promote improved human resource management and quality services in rural areas;

- accelerating the momentum of policy change and improving the overall regulatory environment for health care service delivery through building on the success of the PRIME II Project in expanding the range of RH/MCH care that primary care providers can offer; working to empower local stakeholders to promote effective policy development and dissemination in the areas of service quality (by updating specific RH/MCH clinical guidelines and protocols); improving regulations regarding licensing and accreditation, management and supervision (including seeking approvals for revised position descriptions); and increasing consumer demand and involvement; the project approach will seek to make a significant and long-term impact on policy reform; and

- increasing consumer demand for high-quality RH/MCH care and developing community education and mobilization activities through building on the successful community partnership for health model piloted under PRIME II and expanding it to other marzes, and encouraging additional replication and expansion through building the local capacity of health care professionals and community organizations.

Other activities will be developed by the information and insights gleaned during the community partnership for health process. In this way, a community understanding and perspective inform all four areas of the project. Additionally, the project will work to establish targeted RH/MCH community education efforts designed to increase use of preventive services. Through the integration of these four areas, the project intends to build the capacity of

national and local institutions to sustain such improvements beyond the five-year project period.

Women's Wellness Centers

AIHA has provided technical support over the past 10 years. A Women's Wellness Center (WWC) was established at the Erebouni Hospital in Yerevan and training and infrastructure support has been provided to four primary health care polyclinics in different regions of the country (although USAID has not provided support for these partnerships for over one year). The Armenian American Wellness Center—formally the Mammography Center—is another AIHA partnership that has recently received a four-year Global Development Alliance Grant to continue the enhancement of women's health services and the introduction of family-based primary health care services. AIHA has also provided technical support for the development of a health training facility in Lori Marz that is scheduled to continue receiving USAID funding.

These facilities have benefited from collaboration between several American medical institutions (e.g., Beth-Israel Hospital in Boston, University of California Los Angeles, the University of Rhode Island, and the Center for International Health in Milwaukee, WI). AIHA's programs have strengthened capacity in such areas as antenatal, delivery, and postnatal care; cancer screening, mammography, and cytology training; STI control and infertility services; and the treatment of anemia among pregnant women. AIHA has also given considerable support to strengthening rural ambulatory clinics and working with women's consultation centers to train obstetricians/gynecologists and cytologists in providing screening services for reproductive tract infections (RTIs), STIs, and cervical cancer (e.g., using Pap smears and other laboratory test results). AIHA has also made important contributions in training obstetricians/gynecologists, family doctors, and nurses in new provider standards and protocols.

USAID/Armenia has decided to end its support for AIHA's activities in Armenia as of September 2004. It is not clear whether the Yerevan WWC at Erebouni Hospital will continue to prosper and remain financially sustainable now that external funding from USAID has ended. To date, this facility has shown that it can sustain its operations once its financial ties to USAID have ended. However, the procurement of essential supplies and equipment (especially spare parts for aging equipment) may become a greater problem for the Erebouni WWC once AIHA is no longer active in Armenia.

Social and Health Sector Reform

USAID/Armenia is also supporting efforts to introduce legal and regulatory reforms that will improve the functionality and sustainability of the country's social and health programs. The ASTP is working to improve access to both affordable and high-quality primary care services by developing new training protocols for family medicine, introducing revised training curricula for preservice medical training, and working to improve the administrative capacity of the health care system (including dealing with such civil service issues as staff recruitment, promotion, and retention). The Armenian National Institute of Health and the State Medical University have also developed innovative short-term training programs in RH/FP for family doctors in collaboration with the ASTP.

USAID/Armenia has also been collaborating with other agencies to strengthen the country's health delivery system. For example, World Vision is the principal recipient in implementing nutritional supplementation programs and has recently been awarded funding to develop eight mobile medical teams (including obstetricians/gynecologists for RH/FP) that will serve remote regions of the country. Carelift International has also supplied equipment, pharmaceuticals, and essential technology for USAID–supported training programs in health.

OTHER RH/FP DONOR ACTIVITIES IN ARMENIA

The United Nations Population Fund (UNFPA) is the other principal international donor to reproductive health and family planning activities in Armenia. UNFPA has been instrumental in recent years in providing generous support for contraceptive procurement (largely with funds provided by the Department for International Development [DFID]). However, since these funds are now depleted, it is anticipated that the government of Armenia will be assuming much of the financial burden for supplying contraceptives for its national health care system.

As part of its new country program for Armenia, UNFPA plans to expand its efforts to integrate RH/FP services into primary health care. Family planning cabinets in mixed polyclinics will be upgraded (especially in more remote areas of the country) and family group practice reforms will continue to be promoted in mixed polyclinic settings. Two additional future priorities in UNFPA's country programming will be the expansion of diagnostic and treatment facilities for STIs and the development of facilities specifically designed for youth that provide RH/FP information, counseling, and basic services. UNFPA also plans to increase its support for antenatal care, precancer screening, emergency obstetric care, and mobile RH/FP services. UNFPA's financial resources are insufficient to cover all of these program areas at the national level, which may offer opportunities for collaboration with other donors.

Other United Nations agencies are active in health programming in Armenia. The United Nations Development Programme (UNDP) supports policy development work in HIV/AIDS; the United Nations Children's Fund (UNICEF) works to increase children's access to primary health care, reduce exposure to major childhood illnesses, and improve nutritional intake (especially in poorer more remote areas of the country); and the World Health Organization (WHO) supports a wide array of health initiatives, including health policy and the strengthening of family medicine, maternal and child health, tuberculosis control, and information and surveillance systems for monitoring patterns of disease.

The World Bank has provided two major loans since 1997 to support structural reforms in Armenia's health sector and enhanced service provision of essential primary care to the poor. Recent assistance includes funding to strengthen primary health care services; to train family doctors and nurses at the Yerevan State Medical University, the National Institute of Health, and the Yerevan Basic Nursing College; to support quality improvement in selected hospitals around the country; for technical assistance to the MOH in policy analysis and program monitoring; and to strengthen management oversight for autonomous health care institutions.

Additional international organizations have also been active in the health sector. World Vision is the prime contractor for implementing HIV/AIDS activities financed by the Global Fund To Fight HIV/AIDS, Tuberculosis, and Malaria. Médecins Sans Frontières has undertaken programs for tuberculosis and STI detection and control as well as pioneering mobile medical services in the country. In addition, the German Technical Cooperation (GTZ) is working to reduce morbidity and mortality resulting from tuberculosis in Armenia, Azerbaijan, and Georgia by expanding directly observed treatment, short course (DOTS) treatment programs around the country.

CHALLENGES

Despite the progress made in recent years to improve primary health care through the introduction of family medicine, integrate RH/FP services into primary health care, and improve managerial efficiency in the country's health system, there are still many challenges ahead. Based on field interviews and site visits, several priority programmatic issues that require additional consideration have been identified.

Contraceptive Security

There are continuing commodity supply problems, particularly for affordable contraceptives. Some project sites visited in Armenia did not have IUDs (e.g., Polyclinic 4 and the maternity department of Vanadzor Hospital). Oral contraceptives and condoms were available in project clinic sites, but availability elsewhere in the country was not clear. In the pharmacies visited in Yerevan and Vanadzor, oral contraceptives and condoms were generally available. However, higher quality condoms from Germany were considerably more expensive than less preferred brands from Russia. Norplant is available in some areas of the country (supplied by UNFPA), but is not being used extensively since there has been little training on how to insert and remove the device. Also, there appears to be little demand for Norplant, possibly due to the modest attention given to the method until now.

Strengthening of Primary Health Care

Vague areas still exist with respect to the RH/FP care that family doctors can provide to clients. For example, family doctors are not allowed to insert IUDs or screen for or treat syphilis. There is also some confusion about who should be doing Pap smears; conflicts between family doctors and obstetricians/gynecologists are clearly not fully resolved. It is still not clear whether family doctors are being paid for certain services that they have been trained to perform. This matter needs further clarification with the MOH. In addition, job descriptions for different cadres of health providers are sometimes unclear or unavailable. Job descriptions for family doctors need to be clarified and put into practice.

Client Use of Health Services

Client use of RH/FP care should be a major concern of future program planning. Training new providers, supplying new equipment, and upgrading facilities (e.g., through World Bank support) will not mean much if clients do not access the care. This outcome has been repeated in too many places over the years. The increasing cost of services and low consumer purchasing power are issues that need additional attention, especially in rural

areas. Significant improvements in the quality of care have occurred in numerous pilot sites, but at the same time the accessibility and use of services has been decreasing, especially in the poorest areas of the country.

Possible Rise in Unofficial Abortions

While abortion rates have been declining with the growing use of modern contraception, there are continuing concerns that increased numbers of unofficial, offsite abortions may be occurring. This information is highly anecdotal and therefore not very reliable, but it may suggest a growing need for postabortion care services at polyclinics should more women present with complications stemming from abortions performed in the informal health sector.

Adolescent Reproductive Health and Family Planning Care

Adolescent RH/FP needs may not be adequately addressed by family doctors because of problems of confidentiality and privacy. In order to reach adolescents, separate programs and facilities will likely be needed. UNFPA will be piloting approaches to RH/FP service delivery specifically designed for youth as part of its new five-year country program for Armenia.

Client Referral and the Introduction of Mobile Medical Teams

Referral mechanisms in the Armenian health system seem weak, especially for women residing in rural areas. The introduction of mobile medical teams by UNFPA and USAID (the latter through a contract with World Vision) may help deliver more specialized care to remote areas, but Médecins Sans Frontières' earlier efforts with mobile units proved to be nonsustainable. Introducing workforce strategies that would provide significantly higher salaries for doctors willing to work outside Yerevan (particularly family doctors) should also be given additional consideration.

RECOMMENDATIONS

Enhancing Contraceptive Security and Commodity Logistics Management

Contraceptive security still remains a major problem in Armenia. UNFPA reduced its commodity procurement budget in 2003, and USAID has never provided contraceptive commodity support in Armenia. The government of Armenia plans to start procuring contraceptives next year, but it has a weak commodity/logistics system. USAID may want to consider expanding its technical support in this area. The USAID–supported DELIVER Project has been working with the Armenian government in purchasing and distributing essential drugs. The DELIVER Project in Armenia has recently ended and there are currently no plans to provide new funding for contraceptive procurement.

Providing Increased Advocacy for the Family Doctor Reform Strategy

Increased advocacy is needed to promote family doctor reform of the Armenian health care system. Additional advocacy work by the Family Doctor Association and Association of Midwives could be a useful future endeavor. It was also learned that family doctors could be trained in more areas and provide a greater range of services than

at present. Licensing of family physicians could also be made more efficient. In addition, family doctor education and unified curricula need to be more effectively integrated into preservice medical training. To date, most family doctor training has been for inservice providers.

Strengthening STI Diagnosis and Treatment Capabilities

STI diagnosis and treatment remain a big problem and directly affect problems associated with infertility and the spread of HIV/AIDS. The syndromic management of STIs piloted by PRIME II appears to have achieved some success, but the basic fact remains that many STIs cannot be accurately detected and treated through syndromic management. Laboratory-based diagnostic methods are also needed to back up initial syndromic screening. Like many countries in Eastern Europe, Armenia will require greater assistance in this area. UNFPA is planning to increase its support for STI control programs, but additional efforts will be needed as well.

Making More Effective Use of Training Facilities

Training facilities could be more effectively used for patient care than they are currently. For example, at the AIHA–supported training facility at Polyclinic 5 in Vanadzor, clinical facilities used for training were locked up and not being used to care for clients between training events (typically intervals of several weeks).

Giving Greater Emphasis on Community-Based Preventive Health Interventions

Donor funding for RH/FP (including that provided by USAID) may have been giving too much emphasis to upgrading clinical and curative services and not enough attention to community-based programs emphasizing prevention (e.g., through nutrition and healthy lifestyles) and the availability of care. Further consideration needs to be given to ways of changing the mindset of the general population to be more conscious of RH/FP needs and to overcome the general mistrust of health providers that currently exists.

Clarifying the Growing Confusion Between Public and Private Health Facilities

There appears to be growing confusion between public and private health facilities in Armenia. Many regional public facilities now seem to be operated more like private clinics, with both public and private facilities increasingly recovering costs from client payments rather than public subsidization. There is also growing uncertainty about the level of care being provided in different facilities, including the RH/FP care being offered. During the planned 2005 Armenian DHS, it would be useful to collect detailed information on service facilities (using the DHS facilities module) in order to obtain a more accurate picture of the care that is available, the service provider, the services available, and how different facilities (both public and private) situated at different levels of the health system are equipped and serving clients. Such information could be useful in directing future resource flows for RH/FP programs.

APPENDIX E

USAID SUPPORT FOR RH/FP PROGRAMS IN KAZAKHSTAN

USAID SUPPORT FOR RH/FP PROGRAMS IN KAZAKHSTAN

BACKGROUND

Before 1995, the Kazakhstan health care system was little changed from the days of the Soviet Union. In 1995, the government began a major restructuring of the primary health care system by creating a network of family group practices that were to become financially and managerially autonomous. Clients were to enroll in a group practice of their choice. The government initiated a health insurance fund to pay a capitation fee for these practices. The insurance fund collapsed in 1999, but a World Bank loan was negotiated to replicate the model nationwide in the same year.

According to the 1999 Kazakhstan Demographic and Health Survey (KDHS), the general abortion rate in Kazakhstan was 47 per 1,000 women, a decrease from 71 in 1990. As is the case in other countries in the region, there is some discrepancy between official health statistics and the KDHS. Despite these uncertainties, there is no doubt that the abortion rate declined significantly during the 1990s. During this period, there was a 50 percent increase in the use of modern contraceptive methods that paralleled the decline in abortions. As of the 1990s, 54 percent of all currently married women reported using a modern method of contraception. This is a very high level for the E&E region. However, UNFPA reports that abortion continues to be the leading cause of maternal death in Kazakhstan (43 percent), followed by obstetric bleeding (17 percent) (UNFPA 1999:6).

Over the last decade, USAID funded several large RH/FP projects in Kazakhstan. JHPIEGO and AVSC International (now EngenderHealth) were the pioneers in training providers in RH/FP competencies and donated medical and training equipment. JHU/PCS provided assistance in the development of mass media campaigns on RH/FP issues. The POLICY Project worked to assist the country in RH policy and resource mobilization. The Social Marketing for Change project (SOMARC) implemented the contraceptive social marketing program, and ORC Macro conducted the 1995 and 1999 DHS surveys with USAID funding. USAID also supported the ZdravReform and ZdravPlus projects. These activities aim to integrate RH/FP care with primary health care through family group practices.

FINDINGS

Trends in Selected Reproductive Health and Family Planning Indicators in Karaganda Oblast

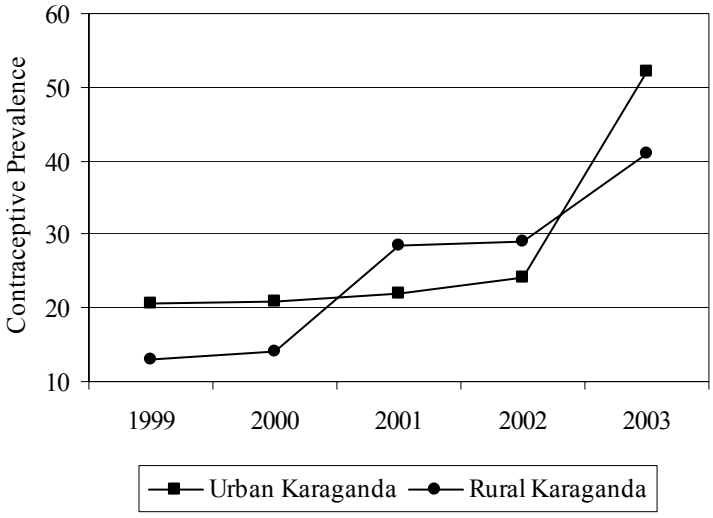
The ZdravPlus Project implemented by Abt Associates Inc., has been working in Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, and Uzbekistan in the areas of health policy, health financing, health sector institutional restructuring, and strengthening primary health care through the introduction of family group practices. A key feature of this effort is the strengthening of RH/FP service delivery by family doctors and nurses/midwives.

In Kazakhstan, the ZdravPlus Project has been working in several pilot sites, including Zhezkazgan, Karaganda City, Uralsk, and Arkalik. Major achievements of the ZdravPlus Project in Kazakhstan include the training of family doctors and nurses/midwives in

family planning counseling and service provision, the distribution of RH/FP educational materials for clients and providers, the introduction of new RH/FP quality assurance protocols, and the provision of essential equipment.

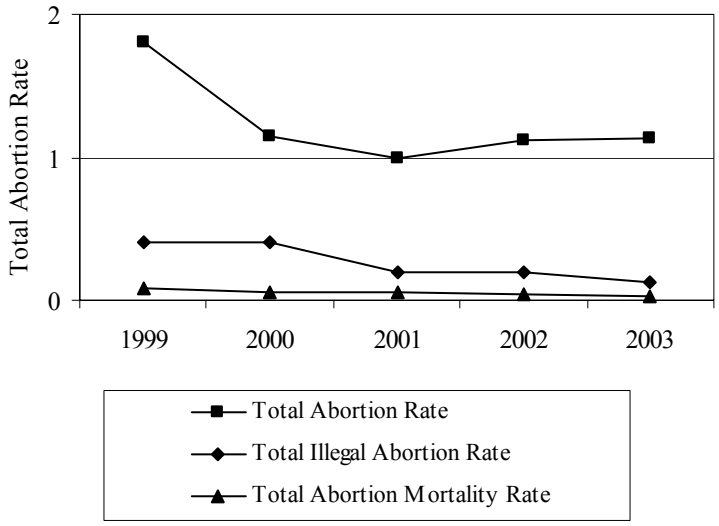
Information compiled by the Kazakhstan Ministry of Health in Karaganda Oblast indicates that efforts to enhance the use of modern contraception, reduce abortion, and improve maternal mortality are proving successful. As is noted in figure E–1, the percentage of women using any form of contraception more than doubled between 1999 and 2003 in both urban and rural areas of Karaganda Oblast. This gain in family planning use coincided with substantial reductions in the total abortion rate and the level of illegal (criminal) abortion (see figure E–2 on the following page). Maternal mortality stemming from abortion also fell slightly over this period, although the reliability of these data are uncertain.

Figure E–1
Percentage of Currently Married Women Aged 15–44
Currently Using Contraception in Karaganda Oblast
(1999–2003)



The maternal mortality rate (MMR), the number of maternal deaths per 100,000 births, has fallen dramatically, from approximately 110 in 1995 to just 30 by 2003. In addition, the MMR for Karaganda Oblast was substantially below national levels by 2002. While it is not possible to directly attribute this improvement to ZdravPlus interventions, the timing of such favorable outcomes does correlate well with interventions championed by the ZdravPlus Project (e.g., the training of family doctors and nurse/midwives in RH/FP).

Figure E–2
Abortion and Mortality Rates in Karaganda Oblast
(1999–2003)



Contraceptive Social Marketing Program

USAID began funding for contraceptive social marketing efforts in 1993 through Futures Group's SOMARC project under the logo of Red Apple. The objective of the project was to develop a sustainable commercial retail market for contraceptive pharmaceuticals. At that time, the central pharmacy, Farmatsyia, an importer, distributor, and retailer of drugs, dominated the pharmaceutical markets. Influencing an almost nonexistent private pharmaceutical sector, therefore, was the challenge of the program.

The project initially forged partnerships between five international manufacturers and local distributors to sell six brands of oral contraceptives, two injectable contraceptives, and one condom. Training of health professionals was a key element of the program conducted by JHPIEGO and by AVSC International. SOMARC led the early market research, advertising, and public relations efforts. The Commercial Market Strategies (CMS) project took over the contraceptive social marketing program in 1999 and continued through 2001.

In 1995, 92 percent of the couples received contraceptive supplies from a public facility. As of 1999, the public sector still was the main source of contraceptives, accounting for 76 percent of all supplies, while the commercial sector provided 20 percent of all methods (KDHS 1995 and 1999). There was, however, wide variation among the methods. The public sector was the main provider of IUDs (86 percent) while the commercial sector dominated oral contraceptives (71 percent) and condoms (64 percent). Given the virtually nonexistent commercial sector at the beginning of the decade, this level of achievement constitutes a success story.

At the time of the assessment, Schering was marketing five brands of combined low-dose oral contraceptives and dominated 70 percent of the oral contraceptive market. Schering's representatives were greatly satisfied by their sales growth, citing that sales had increased

over the last decade, and have doubled annually since 1998. The company has discontinued marketing of injectable contraceptives. However, they had no supplies of Depo-Provera and stated that there had been poor market growth for the product. Schering continues promoting oral contraceptives as a means of avoiding unwanted pregnancies and abortions. The company also maintains a hotline receiving about 200 calls per day, mostly from younger women.

Interfarma–K, a multinational company, is the leading distributor of contraceptive products in Kazakhstan. The company distributes several brands of condoms and oral contraceptives and Mirena, the progestin-containing IUD. However, its stocks of Depo-Provera were temporarily depleted. Interfarma-K's country representative confirmed that sales of all methods have been increasing over the years, particularly condoms and oral contraceptives.

At the time of the assessment, the presence of numerous private pharmacies in Almaty and Karaganda was observed, and several outlets were visited. Up to 15 brands of oral contraceptives and 10 brands of condoms were available at the visited pharmacies, although none of them carried IUDs. The pharmacists noted that IUDs were available at the facilities where they are inserted. None of the pharmacies carried Depo-Provera. Key respondents also noted that IUDs are available in large pharmacies located in cities. In any case, availability of a broader choice of contraceptives, in particular long-term methods, remains an issue for expanding contraceptive use in Kazakhstan.

The Red Apple Hotline

The CMS project initiated a hotline to complement efforts of the contraceptive social marketing program in 1999. Initially placed at the WWC in Almaty, the hotline functioned on a national basis, with all calls being handled by operators based in Almaty. In 2001, support for the Red Apple hotline was transferred to Abt Associates Inc., and was awarded to the Association of Business Women through a competitive bid.

The Association of Business Women decentralized the operations of the hotline by opening local offices in eight cities, of which five are sponsored by Abt Associates Inc., through USAID, while UNFPA and pharmaceutical companies support these operations in three other cities. The decentralization significantly reduced the cost of the hotline and also allowed for the provision of local advice to clients. The Red Apple hotline has proved to be an effective approach for providing up-to-date information to consumers on contraceptive choices and services as well as healthy reproductive and maternal lifestyles. It is convenient, quick, and anonymous. Calls for the hotline have been increasing over the years and the association is committed to continuing and expanding operations by seeking additional domestic and international sponsors.

Health Sector Reform and Development of Family Group Practices

Health sector reform initiatives funded by USAID in Kazakhstan date back to the early 1990s. The thrust of the USAID interventions has been strengthening the provision of primary health care and integrated RH/FP care into primary health care through the introduction of family doctors. This initiative was first undertaken through the ZdravReform Project implemented by Abt Associates. The follow-on project, ZdravPlus,

has continued this initiative and is giving considerable emphasis to improving the quality and efficiency of primary level care in selected pilot areas.

ZdravPlus focuses on the development of pilot sites while supporting ongoing national health policy development. Several pilot sites are quite advanced, and have obtained impressive support from oblast authorities. Technical assistance focuses on increasing the efficiency of the health sector through new provider payment systems for primary and inpatient care as well as management training. In urban areas, primary health care payment systems are influenced by client preferences, giving incentives to providers to improve efficiency and quality of care. Private ownership of primary health care facilities paired with new provider payment systems in Zhezkazgan have resulted in a health care network that is well managed and responsive to community and individual health needs.

Family medicine training that incorporates RH/FP and maternal and child health skills is producing new primary health care physicians that have an expanded scope of service that reduces unnecessary referrals and and enables them to treat patients closer to their homes. Monitoring and evaluation systems, such as the one introduced in Karaganda Oblast, provide information to refine the reform process and encourage providers to improve performance.

Data Collection and Analysis

As in other former Soviet countries, government health departments collect extensive data in order to tabulate an exhaustive list of health care indicators. The quality of data, however, remains questionable, mostly because this information is often used to evaluate the performance of health care managers and providers (i.e., managers/providers are penalized if certain indicator targets are not met in their catchment areas).

Another cause for underreporting, particularly for abortions and STIs, is the increasing involvement of private practitioners. Key respondents acknowledged that private physicians (who are often reluctant to submit reports to government authorities) perform a significant portion of abortions and STI treatments. A recent government order that banned private physicians from providing abortions may have worsened the underreporting of this procedure.

USAID has funded two population-based surveys in Kazakhstan, the KDHS in 1995 and in 1999. These surveys provided valuable data for international donors and the government of Kazakhstan to shape their programs and policies. However, USAID/Kazakhstan does not intend to support another DHS due to the high cost of the operation.

Training of Trainers and Providers

Training of trainers and providers in RH/FP was primarily implemented by JHPIEGO, and to a lesser extent, by AVSC International. Between 1993 and 1997, JHPIEGO worked with several national and regional institutions to develop a cadre of RH/FP trainers and to establish local RH/FP training capacities. Initially, several participants were trained in the United States as trainers, and they consequently provided instruction to local trainers and providers. These efforts have been highly successful, as evidenced through interactions with managers and providers at clinical facilities. Almost all

respondents who provided RH/FP training and/or care cited JHPIEGO–assisted training activities. In addition, training materials developed through JHPIEGO assistance were still available in all sites visited.

Nevertheless, it now appears that training efforts supported by the international community have drifted away from RH/FP over the last several years, probably due to the assumption that a sufficient number of trainers and providers have already been trained in RH/FP.

Women's Wellness Center

USAID funded the establishment of a Women's Wellness Center in Almaty in 1997 through AIHA. The WWC provides integrated women's health services and promotes healthy lifestyles throughout the lives of women. AIHA provided extensive training for the staff and equipment for the centers during the initial phase of the project. Following the opening of an adjacent WWC (also in Almaty), USAID discontinued funding for the centers. The rationale for the discontinuation was that the centers were only capable of delivering vertical women's health services (sometimes with a weak commitment to contraceptive service provision), which is not consistent with USAID's strategy to promote the integration of RH/FP care into the country's primary health care system.

The WWC in Central Almaty is a well-equipped and well-staffed facility, including an outpatient polyclinic and an inpatient clinic. The outpatient clinic has three departments: infertility department, department for children and adolescents, and department of genetics. In addition, there is a 50–bed inpatient hospital serving infertile couples and gynecological patients. Recently, the center has been facing funding problems. The MOH budget is not adequate to replace the medical and training equipment that was donated by donors and has worn out over the years. More alarmingly, the center did not have any contraceptives at the time of the visit.

Contraceptive Availability

USAID and UNFPA have been donating contraceptives for the public sector health system over the past decade in Kazakhstan. USAID phased out contraceptive donations in 2002 and UNFPA greatly reduced its support in 2003. The MOH procures some contraceptives, but the quantities are far from meeting current and projected need. While limited supplies are being distributed to the pilot project sites, the public sector is still facing serious contraceptive shortages nationwide.

OTHER DONOR ACTIVITIES IN KAZAKHSTAN

UNFPA also provides resources for RH/FP activities in Kazakhstan. Its last five-year program cycle (2000–04) was budgeted at $6 million ($4 million from regular resources and $2 million from several bilateral funding arrangements). UNFPA funds both national and regional program activities, concentrating much of its regional funding in East Kazakhstan, Kyzyl Orda, Chimkent, and Almaty.

Much of UNFPA's program activity is directed toward improving the policy environment for RH/FP services within the government's health delivery system. Efforts are being made to upgrade the availability and quality of RH/FP services in mixed polyclinics and

to strengthen hospital-based obstetric services. UNFPA is working with other donors in encouraging the provision of RH/FP services within family group practice service delivery settings. It is also promoting the use of newly developed RH/FP protocols for service providers (primarily family doctors and nurse–midwives) to enhance the quality of provider skills and client–provider interactions. UNFPA plans to increase its support for training in these concise RH/FP protocols during its next five-year project cycle (2005–09) as part of its strategy to reduce maternal mortality, birth traumas, STIs, and abortions. UNFPA has also been active in developing information, education and communication (IEC) programs for adolescent reproductive health, supporting government efforts to more fully integrate population and development issues into poverty reduction strategies, and undertaking advocacy campaigns promoting gender equality, reproductive rights, and the sexual and RH/FP needs of adolescents

Due to budget constraints, UNFPA has had to curtail its support for contraceptive procurement. UNFPA staff in Almaty noted that the greatest short-term challenge to RH/FP programming in Kazakhstan was the need to ensure steady supplies of affordable, high-quality contraceptives. There is concern that the government of Kazakhstan may not have the resources or management infrastructure necessary to provide reliable stocks of contraceptives to public sector health facilities without continued donor support.

Other donors have also been active in supporting RH/FP initiatives. Germany has contributed resources for procuring contraceptives, the Netherlands has been active in population education and school curriculum development, Finland has contributed funding for Kazakhstan's national population census, and the United Kingdom has supported projects concerning adolescent sexuality and RH/FP research. The World Bank has also provided loan money to the government of Kazakhstan to support the introduction of family physicians into the country's primary care polyclinic network.

RECOMMENDATIONS

Strengthen Family Planning Service Delivery in Family Group Practices

Family planning services are not adequately emphasized in many family group practices providing primary health care. There is a need to have family planning more prominently situated within the mix of services provided at polyclinics. Efforts to improve the method mix offered to women in Kazakhstan is essential. Many clients still seem reluctant to use oral contraceptives, IUDs often are not available (especially in more remote rural settings), and injectable contraceptives were not effectively introduced in the country. In future RH/FP advocacy activities, increased emphasis should be given to the health benefits of family planning and other RH care in order to further dispel public perceptions that equate family planning with population control.

Provide Additional RH/FP Counseling Training

In RH/FP training programs supported by USAID, considerable emphasis has been given to developing counseling skills among service providers (Tazhikenova et al. 2004:21). Physicians (especially obstetricians/gynecologists) often are not skilled at providing counseling. In addition, clients often have little understanding of their RH/FP needs and

treatment options. As access to services is improved and more FP cabinets are opened, counseling services will need to be upgraded further.

Improve the Availability of Contraceptives

Prices for most modern contraceptives at pharmacies are high for many disadvantaged customers in Kazakhstan. Pharmacy prices for many RH/FP commodities and drugs are reported to be well above world prices. Recently, rural pharmacies have seen some decline in their sales and may not be procuring enough stock. In Kazakhstan, there appears to be little ongoing market research to measure demand for contraceptives and other essential drugs and supplies in order to judge the ability of the population to pay current market prices. It is recommended that USAID, in collaboration with UNFPA and other donors, should consider supporting a contraceptive security initiative to ensure that adequate contraceptives are available both in the public and private sectors. There is a need to work with the Ministry of Health to ensure that the public sector provides affordable contraceptives to less privileged clients.

Consideration should also be given to introducing an outpatient drug benefit for mothers and infants and to gradually extending benefits to children under 5. This payment could gradually be extended to additional services (including contraception). The payment could also be initially directed to disadvantaged families unable to provide for the costs of basic medical care.

Promote the Integration of RH/FP Care With Evidence-Based Maternity Care

A successful service model supported by USAID in other E&E countries has been the reform of maternity care services using the best evidence available to simplify and demystify the process of childbirth. This model has also proven to be an effective means of providing postnatal and postabortion family planning counseling and care to mothers not wanting to become pregnant soon after having a child.

APPENDIX F

USAID SUPPORT FOR RH/FP PROGRAMS IN ROMANIA

USAID SUPPORT FOR RH/FP PROGRAMS IN ROMANIA

BACKGROUND

Before 1989, the Romanian government pursued pronatalist policies that outlawed contraception and abortion. In 1989, abortion was legalized and limited family planning services were developed, but due to misinformation and service delivery constraints, abortion became a major method of fertility control. Abortion was also widely used since doctors could earn extra compensation by performing abortions in private facilities during their nonworking hours.

In the early 1990s, Romania had one of the lowest rates of modern contraception in the E&E region, while abortion rates soared. By 1990, the abortion rate was one of the highest in the world: 200 abortions per 1,000 women of reproductive age. In 1993, WHO ranked women's health in Romania as the poorest in the region. According to the first nationwide reproductive health survey conducted in 1993, the use of modern contraceptives among all currently married women aged 15–44 was as low as 10 percent.

USAID began supporting an RH/FP initiative in Romania in the early 1990s. Between 1991 and 1997, the Centre for Development and Population Activities (CEDPA) had a pioneering role in the development of Romania's family planning program. First, the project worked with newly established NGOs as part of the institution-building process. There were two pioneering NGOs active in RH/FP, the Society for Education on Contraception and Sexuality (SECS) and the Youth for Youth Foundation (YfY). Second, CEDPA began training the first cadre of family planning providers and trainers in the country. CEDPA provided extensive technical assistance during the initial years of the Romanian family planning program, ranging from institution-building activities to service delivery and educational services.

Building upon CEDPA's work, USAID continued its support for the RH/FP program through several additional projects during the 1990s. Management Sciences for Health (MSH) provided management training and institutional development assistance to NGOs. The POLICY Project worked in Romania from 1997 through 2002, assisting the government with the development of RH/FP policies, including a contraceptive security initiative. Between 1998 and 2000, JHU/PCS implemented a mass media campaign in selected districts to promote RH/FP information.

Subsequently, in 1999, JSI was brought in to implement a comprehensive RH/FP program, known as the Women's Reproductive Health Initiative. In 2001, JSI was awarded a grant to implement the Romania Family Health Initiative (RFHI) as an umbrella project for multiple activities that were previously implemented under separate projects. RFHI partner organizations include PSI and a number of local NGOs, SECS, the Romanian Association Against AIDS (ARAS), YfY, and the East European Institute for Reproductive Health (EEIRH). RFHI is scheduled to end in September 2006.

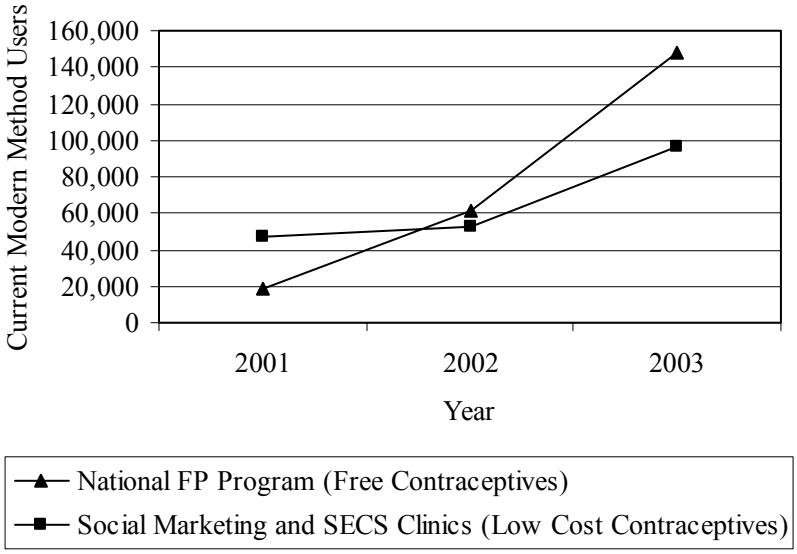
The USAID/Romania Assistance Strategy for Romania 2002–2006 places considerable emphasis on family planning and reproductive health. The plan supports the availability of RH/FP care at the community level and calls for a national rollout effort to reach 40 percent of all 4,000 primary care facilities in the country.

FINDINGS

The Romanian family planning program made rapid progress over the last decade as evidenced by basic indicators. Modern contraceptive use more than doubled from 10.4 in 1993 to 23.5 in 1999, while the total abortion rate declined from 3.4 to 2.2 per woman during the same period (1993 and 1999 RHSs). Maternal mortality, which was among the highest in the E&E region in the late 1980s at 170 per 100,000 live births, is now estimated to be about 60 (Institute of Mother and Child Health Care, Romania).

Between 2001 and 2003, the Romanian government adopted a targeted approach to contraceptive distribution in which free contraceptives were provided to poorer, largely rural clients through the national FP program, while social marketing and NGO clinic distribution (through SECS) came to dominate in urban areas. As is shown in figure F–1, the number of users of modern contraception rose dramatically between 2001 and 2003 with this targeted approach (JSI 2003d:10). Couple years of protection (CYPs) rose by 150 percent in the national FP program, and by over 100 percent through social marketing and NGO channels (JSI 2004a:3–4).

Figure F–1
Number of Active Family Planning Users in Romania
(National FP program, social marketing, and SECS clinics, 2001–2003)



In 1991, USAID was the first international agency to support RH/FP programming in Romania and is still the largest donor in this sector. Another noteworthy feature of USAID RH/FP assistance is its exceptional level of coordination and collaboration with local partners (both governmental and NGO sector players) as well as UNFPA. Following is a summary of USAID–supported activities and initiatives.

NGO Development and Strengthening

In the early 1990s, the Romanian government was in chaos and did not focus on providing RH/FP care. USAID supported the newly emerging NGO sector through CEDPA to begin building local capacities in RH/FP. Two new NGOs were established at that time (SECS and YfY) and received substantial assistance from CEDPA. The intent was to build an exemplary NGO service delivery and education program that would act as an example for the public sector to emulate. These NGOs flourished in their early years.

The government became more involved in RH/FP initiatives by the mid–1990s, in part due to the pressure from the NGO sector, and strong partnerships between the two sectors were developed. Currently, NGOs have a leading role in all aspects of the RH/FP program and continue to receive substantial assistance from USAID as well as other international agencies. SECS is the key training and advocacy institution for RH/FP in Romania, and the MOH relies entirely on it for training its staff. YfY has become a national NGO with 30 branches in 11 districts, providing adolescent sexual and RH/FP education and care on a volunteer basis. Both organizations rely heavily on the work of volunteers in addition to their core professional staff. It is also noteworthy that both of them have become renowned internationally and have begun providing technical assistance to neighboring countries. In addition to these two pioneer NGOs, two others have benefited and continue to receive support from USAID: ARAS and EEIRH.

Training in RH/FP

Training of RH/FP managers, trainers, and providers has been the primary focus of almost all projects funded by USAID. Initial efforts assisted by JHPIEGO were focused on training the staff of 240 newly established family planning cabinets nationwide. Later, training expanded to family doctors, who are the gatekeepers of the system and have an important role in the provision of primary health care, especially in rural areas.

The JSI–supported RFHI project focused on developing training curricula in accord with international standards for each professional group. Training curricula were developed and piloted in collaboration with the MOH and are now being used on a national level. The project also assisted in preparing guidelines for family planning services in accord with WHO recommendations for contraceptive use. These guidelines are being used in FP training for primary health care providers. UNFPA continues to support many of the same training initiatives.

Integration of RH/FP Care into Primary Health Care

Romania has undertaken an ambitious program of health reforms, but implementation has been difficult and inefficiencies remain. The health sector reforms designated general practitioners as family doctors and authorized them to provide RH services. However, family physicians typically lacked training in many basic competencies, especially reproductive health and family planning. In addition, general practitioners and nurses were typically underused and routine service needs were often referred to specialists.

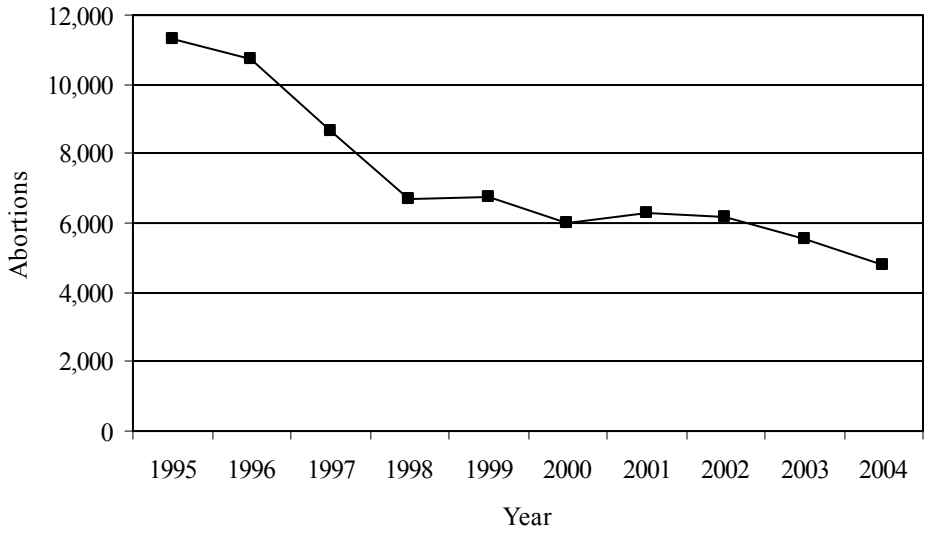
The USAID–funded RFHI Project employs a three-pillar approach for integrating RH care into primary health care. The approach incorporates three essential elements of

service delivery (i.e., training, commodity availability, and BCC activities). To date, more than 2,300 family doctors working in rural settings in all 42 districts have been trained in basic RH care. The majority of project resources has been devoted to increasing awareness and promoting use of family planning through outreach and interpersonal communication efforts. An innovative approach employed by RFHI to expand access to RH care has been to create linkages between RH care and HIV/AIDS programs and strengthen efforts to combat violence against women.

RFHI assisted in the development and implementation of a logistics management information system (LMIS) as a tool for managing contraceptive commodities. The LMIS tracks distribution and consumption of contraceptive commodities and forecasts procurement needs. By the end of 2003, installation and training for the use of LMIS had been introduced to all 42 districts.

Integration of RH/FP into primary health care in rural areas is now expanding nationwide. Data from Cluj, a district visited by a team member, provides promising results in terms of increasing contraceptive use and reduction of abortions. The number of reported abortions in the district declined from 11,300 in 1995 to 5,500 in 2003 (see figure F–2).

Figure F–2
Number of Abortions in Cluj District, Romania
(1995–2004)



Policy Dialogue and Contraceptive Security

USAID projects have been actively involved in health sector reform efforts and policy dialogue in Romania over the last decade in order to overcome the legal and regulatory framework stemming from the communist era. Progress has been made in changing the regulatory and policy environments affecting RH/FP. As a result of a long consensus-building process involving key stakeholders, a national sexual and reproductive health strategy was developed and widely distributed in 2003.

A significant policy change that occurred as a result of advocacy and policy efforts is the authorization of general practitioners (now called family doctors) to provide family planning services at primary health care facilities. Previously, only general practitioners who worked in family planning cabinets located in urban areas and obstetricians/gynecologists could provide this care.

Extensive national-level policy discussions increased funding for RH/FP activities. For the first time in 2001, the MOH allocated resources for procuring contraceptives to be distributed free of charge to the poorest segments of the population. Those eligibile for free contraceptives include rural residents, youth, the Roma ethnic group, and women who have recently undergone abortions. The MOH's contraceptive budget has been increasing since 2001 and reached $1 million in 2004. Finally, in 2002, the Ministry of Finance and the House of National Health Insurance approved coverage of contraceptives by the national health insurance system.

Women's Wellness Center

In the mid–1990s, a WWC was established in the northern district of Iasi with funding from AIHA. The center provides integrated women's health services similar to WWCs established in other E&E countries. AIHA ended its activities in Romania several years ago and the center was transferred to the MOH.

Data Collection, Analysis, and Dissemination

National health services data have been erratic and incomplete in Romania. In the RH/FP area, abortions and STIs are often underreported. USAID therefore funded two population-based surveys, in 1993 and 1999, to measure coverage of RH/FP care and changes in contraceptive behavior. A follow-up reproductive health survey jointly funded by USAID and UNFPA was to be conducted in 2004–05. USAID and local partner organizations have extensively used the results of reproductive health surveys to determine priorities and resource allocations.

CHALLENGES

Despite impressive progress to date, many challenges remain in meeting the RH/FP needs of Romanian women and men. The maternal mortality rate is still very high compared with countries of similar social and economic status. In spite of rapid positive changes in contraceptive use and reduction of abortions, substantial unmet need remains.

Contraceptive Availability

All of the activities summarized above have led to a substantial demand for RH/FP care in Romania and demand will most likely accelerate in the near future. Over the last decade, the Romanian program relied on contraceptive donations from UNFPA and USAID. Both organizations have ended contraceptive donations recently and do not plan to provide them in the foreseeable future. At present, the quantities of contraceptives procured by the MOH can only meet partial demand. Once the contraceptives provided by donors are depleted, Romania will face a crisis unless the government can substantially increase its budget for contraceptive procurement. In fact, efforts to

integrate RH/FP into primary health care (especially in rural areas) have clearly been inhibited by the shortage of contraceptives. Contraceptives are available in the commercial sector, but affordability and accessibility are major barriers for many couples.

Sustainability

As the Romanian RH/FP program matured, projects supported by USAID focused on the sustainability and replicability of their activities. Current interventions supported by the RFHI are largely aimed at strengthening local capacity to provide RH/FP care. Local partner institutions, in particular NGOs, continue to rely on USAID and UNFPA. Given the fact that UNFPA's program in Romania is much smaller, USAID continues to be the main source of support for the RH/FP program. For example, SECS currently relies on USAID support for 70 percent of its budget.

Remaining Policy Barriers

A number of policy and regulatory barriers to expand and strengthen availability of RH/FP care still remain. For example, the linkages between primary health care facilities and special family planning services provided through family planning cabinets in urban areas are still weak and need to be strengthened. In addition, while general practitioners are authorized to provide family planning services at primary health care facilities, they are not allowed to insert IUDs (only gynecologists can insert them).

RECOMMENDATIONS

Continuity of Support

USAID should continue to support the Romanian RH/FP program to ensure the sustainability of program gains. Worldwide experience has shown that the development of sustainable, high-quality RH/FP programs requires a long-term commitment from the donor community. In the E&E region, much RH/FP work remains unfinished.

Contraceptive Security Initiative

USAID should continue to support a comprehensive contraceptive security initiative in collaboration with relevant stakeholders, including pharmaceutical companies. The Romanian government may have to revise its eligibility criteria for free distribution of contraceptives; these criteria are defined very broadly and cover large segments of the population. For example, all rural residents and youth are entitled to receive free contraceptives. In addition, the pharmaceutical sector has considerable potential to have an even greater role in expanding contraceptive choice and availability.

Donor Coordination

Although Romania is only a few years away from entering the European Union (EU) (the country will be a full member in 2007), the EU does not invest in Romania's health and education sectors. USAID can have a critical role by raising awareness within the EU's leadership on RH issues in Romania and encouraging greater EU financial contributions in this area.

Special Programs

USAID's current strategy to expand the availability of RH/FP for rural populations has been successful in addressing the needs of the rural poor. For example, outreach programs to meet the needs of the underprivileged Roma populations in urban areas would greatly enhance their RH status. Interventions to reach women who have undergone abortions could be a potential strategy. Despite thousands of women undergoing abortions each year, an organized effort to help women practice family planning following an abortion does not exist. Primarily because of the fragmentation of abortion and family planning services in urban centers, many women leave facilities without receiving family planning counseling. Two independent, pilot postabortion FP projects not funded by USAID are currently underway to explore different approaches. The results of these interventions should be analyzed for the potential expansion of pilot programs.

APPENDIX G

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REFERENCES

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